Participatory Action Research with Chinese Co-Researchers Who Have Serious Mental Illness Diagnoses

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ABSTRACT

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Engaging with marginalized communities to address issues of importance to their emotional well-being is central to counseling psychology's core missions in social justice advocacy. Among those who have been historically viewed as deficient and marginalized are people who have been diagnosed with a serious mental illness (Schneider, 2012). Community-based psychosocial interventions have been identified as an effective form of treatment, particularly when they emphasize collaboration with community members, the empowerment of people with serious mental illnesses, the ability of such individuals to take action on behalf of themselves and others, and ownership of findings and knowledge by all partners (Corrigan & Garman, 1997; Davidson et al., 1999; Salzer, 2002). This dissertation study represents an attempt to position participatory action research (PAR) as such an intervention in the context of two marginalized identities—ethnic Chinese minority identity and the bearing of a serious mental illness diagnosis. The launching, design, and analysis of the PAR process with this population was tracked to examine the potential strengths and challenges of its utility in relation to Chinese survivors of serious mental illness. Through collaboration and dialogue, the project identified and addressed topics that the PAR co-researchers (the Chinese community members diagnosed with a serious mental illness) experienced as significant problems in their specific settings and took actions that resolved those problems, thus bridging theory and discussion topics with real-world situations,

issues, and experiences, and leaving the community co-researchers and their respective agency better prepared to create such action in the future.

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CHAPTER I

INTRODUCTION

As a psychological specialty, counseling psychology has placed diversity and social justice advocacy at the center of its professional identity (Council of Counseling Psychology Training Programs, 2009). One aspect of social justice advocacy is engagement with social groups and communities who experience sociocultural marginalization to address issues of importance to their emotional well-being (Smith & Romero, 2010; Torre & Fine, 2005). Among those groups who have been historically viewed as deficient and marginalized in society are people who have been diagnosed with a serious mental illness (Schneider, 2012).

According to The Office of Mental Health of New York State, a person is considered to have a serious mental illness if he or she has a designated mental illness according to a DSM-IV psychiatric diagnosis, in addition to a) a disability and/ or marked difficulties with self-care, significant restriction of activities of daily living, b) marked difficulties in maintaining social functioning, and/ or frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner, and/or need to rely on psychiatric treatment, rehabilitation and supports (OMH, 2011). Researchers often use the term serious mental illness in reference to some form of schizophrenia spectrum psychosis (Davidson, Borg, Marin, Topor, Mezzine & Sells, 2005; Deegan & Drake, 2006; Phelan, Yang, Crus-Rojas, 2006) and/ or bipolar disorder and major depression (Druss & Bornemann, 2010; Phelan, Yang, Crus-Rojas, 2006). These individuals have also been referred to as consumers/service-users/survivors of serious mental illness (Nelson, Ochocka, Janzen & Trainor, 2006).

Serious mental illnesses are often treated through the use of psychoactive medication and other medical interventions, and emerging knowledge of the genetic and biological components

of mental illness has contributed to such advances in treatment (NIMH, 2012). Although medication management is often considered to be an essential part of treatment, it is only one factor in recovery. Psychosocial interventions that promote the development of meaningful relationships (Deegan, 2003; Schneider, 2012), peer support (Deegan, 2003; Anthony, 1993), and personal empowerment (Shmutte, Flanagan, Bedregal, Ridgway, Sells, Styron & Davidson, 2009; Schneider, et al., 2004; Anthony, 1993) have also been identified as integral to the recovery process. Yet, collaborative social experiences are often diminished or even eliminated in the lives of people whose diagnoses relegate them to isolating caregiving settings.

Effective psychosocial approaches have included the use of community-based support programs (e.g., Davidson et al., 1999). Deinstitutionalization policies in the 1960s and 1970s slowed the admission of people with mental illnesses to hospital wards, and spurred a surge of recovery-oriented mental health group establishments outside of hospitals as "a network of caring and responsible people committed to assisting a vulnerable population meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community" (Turner & Schifren, 1979, p. 2). Many of these programs emphasized the empowerment of people with serious mental illnesses and the ability of such individuals to take action on behalf of themselves and others (Corrigan & Garman, 1997; Davidson et al., 1999; Salzer, 2002).

Participatory action research (PAR), which is sometimes referred to as community-based participatory research (CBPR), corresponds in many ways to the tenets of such programming. PAR is similar to peer-led or self-help groups in that it offers peer support, community collaboration, advocacy to create systems-level change, and opportunities for consumer/ survivors to develop skills and create resources based on consumer/ survivor knowledge and

artistic and cultural activities (Janzen, Nelson, Trainor & Ochocka, 2006). Furthermore, PAR engages community members as co-researchers to examine research topics that are important to them through a collaborative approach that challenges conventional structures of decision-making in service organizations (Green et al., 2003). Furthermore, PAR promotes co-learning (McDaid, 2009) and offers an empowering process that encourages social equity, a focus on health from positive and ecological perspectives, and the ownership of findings and knowledge by all partners (Israel et al., 1998; McDaid, 2009).

Finally, PAR / CBPR may be especially relevant for the mission of counseling psychologists. PAR emphasizes honoring and valuing diverse experiential, creating environments that are characterized by respect and trust, and sharing power in order to take action and create lasting social justice change (Stacciarini, Shattell, Coady & Wiens, 2011; Minkler, 2005). PAR has been recognized for positive outcomes in health-related efforts, such as consumers reporting an increased sense of satisfaction and control with regard to service provision (Roth, 1996); increased therapeutic contacts and communications within the mental health system (Schneider et al., 2004); experiencing more personal empowerment and confidence in decision-making (McDaid, 2009); and contributing to the reported well-being of people living with a psychiatric disability (Schneider et al., 2004; Magliano et al., 2009).

Despite its impact, reporting of PAR projects is relatively infrequent within the mental health literature, especially with ethnic and cultural minority populations (Stacciarini, Shattell, Coady & Wiens, 2010). A review of PAR/CBPR by Stacciarini, Shattell, Coady & Wiens (2010) in several electronic databases revealed that less than 20 studies had been conducted using PAR with minority populations in the U.S. The authors found that approximately only 1/5 of those studies examined the utilization of PAR to address mental health in minority populations

(Stacciarini, Shattell, Coady & Wiens, 2010). This finding is striking since according to recent U.S. Census Bureaus (2010; 2017b), the percentages of people of color in the U.S. population are rising, with the percentages of Asians growing fastest compared to those of any other major race group. Furthermore, Chinese Americans comprise the largest Asian group -- yet none of the PAR studies focused on the specific development and treatment needs of the U.S. Chinese population with serious mental illness.

When the treatment needs of diverse populations are considered, cultural issues and structural issues intersect in the delivery of effective, appropriate services (Sue & Zane, 2009). With regard to Chinese Americans, culture-specific beliefs, values, expectations, attitudes, and explanatory models shape the way Chinese view serious psychiatric disorder. The Confucian work ethic and the concept of *face* – or the giving and receiving of social capital, respect and honor -- shape the help-seeking behavior of people with serious mental illness. Central to Confucian collectivistic values is fulfilling the moral obligations that help one's family to prosper, accrue necessary resources, and address "what matters most" in order for the individual and his/her social network to maintain good moral standing in society (Yang & Kleinman, 2007). In this respect, Chinese culture prioritizes actions that promote "face," social reciporocity, and a "felt flow of engagements" in order for one's community and network of individuals to thrive and thereby sustain the faces of all who have membership in the network (Lee-Wong, 2000; Yang & Kleinman, 2007). For people who have serious mental illnesses, it is difficult to participate in social obligations and reciprocity in the same way. Their impeded social participation threatens the status and prestige of their networks, thus preventing them from achieving full citizenship and moral standing in the community (Kung, 2004; Yang et al., 2006). Concealment of the illness may be one way to prevent stigma. Consequently, individuals may be

reluctant to maintain any social bonds, much less "out" themselves by utilizing mental health treatment. This withdrawal and isolation can lead to increased risks of strained and conflicted family relationships, an inability to achieve what matters most to the individual and his/her community, and a poorer prognosis for recovery (Yang & Kleinman, 2008). Therefore, mental health services must not only work to minimize disease symptomatology, but also to focus on the restoration of social connections and community participation in order for the individual with serious mental illness to become a respected and full citizen of the community again.

Given its emphasis on collaboration, empowerment, and advocacy, PAR has the potential to function as a psychosocial intervention that could facilitate the psychological well-being of people with serious mental health problems. It has previously been used in medical and other human-services-based projects as an approach for community members to experience more empowerment by naming local and individual issues, engaging in research to explore them, and ultimately proposing and/or taking action (e.g., Smith & Romero, 2010). Though PAR is not conventional research nor conventional mental health programming, it has immense potential to create practical knowledge about issues and problems of concern as it promotes personal and social change (Wang, 2010). Additionally, the philosophy and implementation of PAR can offer a unique alternative to conventional psychosocial approaches that has proved unsuccessful for ethnic minority groups such as Chinese individuals' underutilization of mental health services (Sue, Zane, Hall & Berger, 2009). In particular, many Chinese in the U.S. are first and second generation immigrant families, which in itself creates a unique set of characteristics and needs that PAR could support in a flexible, culturally sensitive manner.

The goal of this study was to explore the utilization and fit of a PAR approach as part of the recovery process for Chinese people living with schizophrenia in the U.S. The study also

represented an attempt to share power and support the voices of this highly disenfranchised and marginalized group within a social justice framework. As part of this study, Chinese cultural beliefs, values, and attitudes regarding serious mental illness were considered in examining the parameters of culturally competent service. Similarly, an analysis of the PAR process will be presented to examine the potential strengths and challenges of its utility in relation to Chinese survivors of serious mental illness. Through collaboration and dialogue, the project aimed to identify and then address topics that were important to our Chinese community members diagnosed with a serious mental illness who served as co-researchers of this dissertation. As in all PAR projects, the study proceeded through stages of information-gathering, data interpretation, and action planning. Along the way, the study attempted to increase the connection between everyday problems experienced by the co-researchers in their specific settings and the actions that could resolve those problems, thus bridging theory and discussion topics with real-world situations, issues, and experiences, which could leave co-researchers better prepared to create such action in the future.

CHAPTER II

REVIEW OF THE LITERATURE

Although participatory action research (PAR) may be best known as an approach to research methodology, PAR can also be considered to be a community-based intervention with the potential to make a significant impact within the mental health recovery movement. This literature review will explore this contention by, first, providing an overview of serious mental illness. Specifically, the history and evolution of mental health conceptualization and treatment will be presented, along with the influence of multicultural and social justice perspectives within treatment and the development of community-based self-help initiatives that have promoted concepts of mental health recovery, including empowerment, equity, and community-building. Next, PAR, which will be addressed more closely, along with a review of the history and development of PAR, how PAR projects have been implemented, PAR's utility and sensitivity to address the needs of diverse populations and cultural groups, and its power as a socially-just mental health practice.

Following this discussion, the chapter will turn specifically to mental health issues at the intersection of two marginalized identities—a) Ethnic Chinese minority identity and b) the bearing of a diagnosis corresponding to serious, chronic mental illness. The current demography of Chinese and mental illness in the U.S. will be profiled, including responses to traditional and contemporary types of treatment; critical cultural and philosophical components guiding treatment behavior and service utilization; and the social mechanisms of mental illness stigma within the local cultural context that influence treatment of serious mental illness for the population. Following that, we will consider how the aforementioned factors may interact with community-based treatment interventions. Conventional and community-based approaches that

have been applied to the population will be presented, along with studies that have emerged from a participatory action research paradigm. Lastly, we will consider what PAR could potentially achieve with this population, and how Chinese ethnic minorities with serious mental illness and their communities could benefit from an emancipatory and social justice approach such as PAR.

Serious Mental Illness and its Treatment: Diversification and Cultural Competence

The conceptualization and treatment of mental illness have evolved over the decades. The *zeitgeist* of treatment models and scientific research are always reflective of the values and beliefs of the particular period. As Drake et al., (2003) put it, "researchers study the phenomena as they are currently conceived, the treatments that are currently considered promising, and the outcomes that are currently valued" (p. 428). Over the years, the paradigm for understanding serious mental illness has diverged from intrapsychic and parental influences to a biopsychosocial model that integrates neuroscience and psychosocial factors. Although neurological understanding still plays a vital role in how psychopathology is understood (Hert et al., 2011), the ideology of community mental health and the emphasis of rehabilitation and recovery has been gaining increasing attention and support since the 1960s and 1970s (Anthony, 1993; Davidson, O'Connell, Tondora, Lawless, & Evans, 2005). Also known as deinstitutionalization, community psychiatric rehabilitation radically shifted from a reliance on state hospitals to meet the multiple needs and wants of people with serious mental illnesses to a more community and holistic approach to meet the complexities of treatment, rehabilitation, and recovery (Davidson et al., 2005).

What Do We Mean by Serious Mental Illness?

According to The New York State Office of Mental Health (OMH), a person is considered to have serious mental illness (SMI) if they have a designated mental illness

according to a *Diagnostic and Statistical Manual of Mental Disorders- 4th Edition (DSM-IV)* (APA, 2000) psychiatric diagnosis, in addition to a disability and/ or marked difficulties with self-care, marked restriction of activities of daily living, marked difficulties in maintaining social functioning, and/ or frequently compromised ability to concentrate or persist in completing tasks in a timely manner, and/or need to rely on psychiatric treatment, rehabilitation and supports. Serious mental illness has also been defined as "medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning" (NAMI, 2009). Accordingly, mental illnesses are understood as medical conditions that often result in diminished capacity for coping with the ordinary demands of life. Similarly, the federal legislation explains that serious mental illness is a mental disorder that substantially interferes with one's life activities and ability to function. The convergence of the various delineations of SMI is most captured by the US Federal Public Law 102-321, which defines SMI as "any DSM disorder excluding V codes (conditions not attributable to a mental disorder, such as academic problems or malingering, that are a focus of attention or treatment), substance use disorders, and developmental disorders that lead to substantial interference with one or more major life activities." Life activities within this definition include "basic daily living skills such as eating and bathing, instrumental living skills (e.g., maintaining a household, managing money, getting around the community, and taking prescribed medication), and functioning in social, family, and vocational/educational contexts." (Kessler et al., 2001, p. 990). Examples of DSM-defined mental illnesses include Anxiety Disorders, Bipolar Disorder, Depression, Eating Disorders, Panic Disorder, Post-traumatic Stress Disorder (PTSD), Substance Abuse Disorders, and Schizophrenia. Often, researchers also use the term SMI to indicate the presence of psychosis (Dunn, WeWiorski & Rogers, 2008), and this term has additionally been used to describe a form

of schizophrenia spectrum psychosis (Davidson, Borg, Marin, Topor, Mezzine & Sells, 2005; Deegan & Drake, 2006; Phelan, Yang, Crus-Rojas, 2006) and/ or bipolar disorder and major depression (Druss & Bornemann, 2010; Phelan, Yang, Crus-Rojas, 2006).

Conventional Approaches to the Treatment of Serious Mental Illness

Whereas many psychological concerns and disorders are routinely managed on an outpatient basis and without pharmacological intervention, individuals bearing serious DSM diagnoses may have experienced hospitalization and/or used medication and continuing day treatment services to help maintain their daily functioning level. A full examination of the treatment of serious mental illness is beyond the scope of this discussion, yet according to the National Survey on Drug Use and Health, the most common types of treatment of mental health issues were prescription medication (52.6 percent), outpatient services (40.5 percent) and inpatient services (7.5 percent). Concerning prescription medication, antipsychotic drugs are prescribed for psychiatric conditions 99 percent of the time, including mood disorders (39 percent), schizophrenia or other psychotic disorders (35 percent), cognitive disorders such as dementia (7.4 percent), and anxiety (6 percent) (Mark, 2010). There is also research suggesting that people are not receiving adequate services for their mental health issues. In 2002, Wang, Demler, and Dessler found that the percentage of people with SMI receiving any treatment ranged from 7.3 percent for those with non-affective psychoses to 48.5 percent for those with anxiety disorders. People with SMI who did not receive minimally adequate mental health treatment ranged from 78.2 percent among those with mood disorders to 95.9% among those with nonaffective psychoses. Minimally adequate treatment was lowest in the extremely vulnerable group with non-affective psychotic disorders, with an approximate of 1 in 20 that receives minimally adequate care. The authors concluded that on the basis of 1999 US Census

Bureau data, the estimates translate to more than 8.5 million individuals with SMI in the US population who do not receive minimally adequate treatment each year. Wang et al., (2005) again looked at the twelve-month use of mental health services in the US through the National Comorbidity Survey Replication for more recent trends in minimally adequate mental health treatment (the World Health Organization's World Mental Health Survey Initiative version of the Composite International Diagnostic Interview). Again, the authors found that only 32.7 percent of treated individuals were classified as receiving at least minimally adequate treatment. The low percentage of individuals receiving minimally adequate treatment is further supported by the data collected by the Office of Mental Health on Behavioral Health Organizations, which found that the percentage of mental health discharges followed by two or more mental health outpatient visits within 30 days is only 31 percent among the adult age group. Findings from Wang et al.'s (2005) study also indicated that the probabilities of treatment being at least minimally adequate were highest in the mental health specialty sector and lowest in the general medical sector. One noteworthy finding in this study was the frequent use of treatments with uncertain benefit, also known as Complementary and Alternative Medicine (CAM). The authors speculate that the appeal of CAM may be related to a higher orientation to client-centered care and recommend providers of current services to adopt legitimate aspects of the CAM approach. Other findings from the study include, male clients having a considerably higher probability of receiving adequate treatment than female clients, and the lower overall rate of treatment (minimally adequate or not) among racial and ethnic minorities, perhaps due to experiences of mistreatment due to prejudice as documented in related studies in minority communities (Wang et al., 2005).

Influence of Multicultural and Social Justice Perspectives within Psychological Treatment

Multicultural and social justice psychologists have urged attention to the broader social context in which serious mental illness is embedded, with many such examinations emerging within the specialty of counseling psychology (Vera & Speight, 2003; Hall, 1997). Counseling psychologists have emphasized that a social justice perspective emphasizes societal concerns, including issues of equity, self-determination, interdependence, and social responsibility (Sue, Arredondo & McDavis, 1992; Arredondo & Toporek, 2004). Vera and Speight (2003) explained that social justice and multiculturalism require a political analysis of the problems of oppressed groups and the discrimination and prejudice that make up for the inequitable experiences of people, women, gay, lesbian, bisexual people, the young, the old, and people diagnosed with a psychiatric disorder (among others) in the United States. Feminist scholars have also long advocated for a more political analysis in the operationalization of multicultural competency and have challenged for a broader expansion of professional roles in order to be truly grounded in a social justice commitment to eradicate oppression (Walters, Carter, Papp, & Silverstein, 1988; Brown, 1997; Prilleltensky, 1997). Similarly, Sue and Sue (2008) argued fully-developed multicultural competence includes the ability to function as a change agent at an organization, institutional, and societal levels.

Supporting this emphasis on multicultural competence is the steady racial-cultural transformation of the citizenry in the U.S. Population trends indicate that non-Hispanic whites will no longer be the majority of the population in 2042 (U.S. Census Bureau, 2010). Given the cultural and phenotypic diversity between the waves of immigrants from Asia, Latin America, and from South and Eastern Europe, the levels of racial and ethnic mixing and an increased awareness of multiracial ancestry are likely to reshape U.S. racial and ethnic boundaries in the coming centuries (Perez & Hirschman, 2009). These changes coincide with reports of the

inability of the pre-existing mental health care system to effectively tend to the psychological needs of the culturally and racially diverse groups in our society (Carter, 1995; Hall, 2001; Sue, Bucceri, Lin, Nadal & Torino, 2007). Accordingly, the mental health profession has been pressed by community activist groups such as the National Alliance on Mental Illness (NAMI), the National Coalition for Mental Health Recovery (NCMHR), and Mental health Activists in Partnership (MAP) to promote a more culturally-competent, socially just approach to their work to allow the psychological needs and well-being of historically marginalized racial-cultural groups to be more effectively, respectfully, and ethically addressed (Sanders, Noel & Campbell, 2004).

Along these lines, multicultural and social justice perspectives have influenced the evolution of mental health treatment (Sue, Arredondo & McDavis, 1992; Sue & Sue, 1990; Ponterotto & Casas, 1991). For example, Sue and Sue (1990) brought to attention the political nature of counseling and the impact of the counseling profession as "the handmaiden of the status quo" and "transmitters of society's values." In their call for action, Sue, Arredondo and McDavis (1992) recommended changes to the bylaws and ethical standards in government-sponsored psychological bodies "to promote and encourage the highest standards of ethical and professional conduct for multicultural counseling and development" (Strategic Plan for the Association for Multicultural Counseling and Development, 1990, p.6). One of the themes within these examinations concerns community activism with local members of the community (Council of Counseling Psychology Training Programs, 2009). More specifically, counseling psychologists have been called to engage with community members and social groups that may be devalued and/or obstructed from experiencing full participatory citizenship within broader society, such as people of color (Helms & Cook, 1999), poor people (Yeh, Kim, Pituc, & Atkins,

2008; Smith, 2013), and sexual minorities (Fukuyama & Ferguson, 2000). As discussed earlier, people who have been diagnosed with a serious mental illness may also be thought of as a stigmatized, socially-excluded group. The stigma attached to bearing a serious mental illness label has been described as "a major obstacle to recovery, limiting opportunities and undermining self-esteem" (Wahl, 1999, p. 467). Wahl's (1999) study on mental health consumers concerning their experience of stigma and discrimination showed that people with the label continue to "find themselves shunned, avoided, and treated as less competent" in impersonal settings with strangers, social settings such as with friends, family members, church congregations and even mental health caregivers, and in institutional settings, such as being discriminated against from employment, insurance, and volunteering opportunities (p. 475). Furthermore, stigma experiences hurt, anger, and can cause lasting damage to the person's self-esteem that contributes to symptoms (such as depression, anxiety, and withdrawal) of the illness that the person is trying to recover (Link, Yang, Phelan & Collins, 2004). Fears about stigma could result in limiting the possible experiences of more stigma and discrimination, such as a reluctance to participate in treatment or vocational opportunities due to fears about disclosure and community rejection. In essence, “stigma experiences have produced conditions antithetical to the goals of recovery” (Wahl, 1999, p. 476).

Community-Based Approaches to Mental Health Treatment

The U.S. mental health system and services for people diagnosed with serious mental illness have undergone change in recent decades. Mental health reform has led to the closing of state public mental hospitals, resulting in the decrease of resident population from 559,000 to 154,000 (Koyanagi, 2007) from 1955-1980 alone, and an upsurge in rehabilitation in community settings (Davidson & Roe, 2007). Support for community rehabilitation has come from several

sources. Critiques of psychiatric institutions were spearheaded by the growth of mental health service consumers/ survivors, who are people who have been diagnosed with mental illnesses and are working together to make change in the mental health system and society, along with policymakers, dissident professionals, and patient's rights activists (Davidson, Chinman, Kloos, Weingarten, Stanyer, & Tebes, 1999; Davidson, Chinman, Sells, & Rowe, 2006; Davidson & Roe, 2007); family members of consumers advocate for improved services to assure that every person with a mental illness diagnoses has the opportunity for the best treatment and quality of life (Lefley, 1996Glynn, Cohen, Dixon, & Niv, 2006); and increased recognition of the benefits of participation in community life in treatment recovery such as experiencing,

> Self-determination and such normative life pursuits as education, employment, sexuality, friendship, spirituality, and voluntary membership in faith and other kinds of communities beyond the limits both of the disorder and of the mental health system, and consistent with the person's own goals, values, and preferences (Davidson & Roe, 2007, pp. 464).

Community-based self-help initiatives. Community-based consumer/survivor initiatives have spawned consumer-run self-help organizations in which members become active decision-makers in their own courses of treatment. They were developed by survivors who had experienced psychiatric hospitalization in an effort to provide alternatives to what was considered as an oppressive and abusive mental health system (Trainor, Shepherd, Boydell, Leff & Crawford, 1997). These individuals also sought to change the economic and social discrimination experienced by individuals with psychiatric histories. In this context, the term *survivor* refers to an individual who currently access or have utilized mental health services in the past, or who consider themselves survivors of interventions by psychiatry, or who identify

themselves as ex-patients of mental health services (Cohen, 2005: Corrigan, Patrick, Roe & Tsang, 2011). Consumer-run support groups (also known as peer-run services, consumer-run services, or alternative services) can be defined as "any mutual support oriented initiative directed by people with mental illness or their family members" (Brown, Shepherd, Wituk & Meissen, 2008, p. 105). Relatedly, self-help mutual aid groups are related to these initiatives but include "active ingredients" where experiential knowledge can be shared, role models of recovery and healing are present, and social support and valued organizational roles are available (Randall & Salem, 2005, p. 174). These groups have been recognized as providing service users with the ability to experience personal empowerment, promote self-agency in others, and advocate for change on personal and organizational levels, which is often lacking for individuals who receive services in the traditional mental health system (Randall & Salem, 2005). The self-help movement has featured consumer-run mental health treatment for people with SMI (Rogers et al., 2007). Studies have found that consumer-run self-help organizations can have beneficial effects for members involved in those organizations (Pistrang, Barker & Humphreys, 2008). In fact, the literature on consumer-run support groups suggests that participation in those groups have been correlated with decreased re-hospitalizations (Burti et al., 2005), improved social functioning among service users, and decreased caregiver burden (Cohen et al., 2012).

Self-help groups and inpatient facility utilization. Within this literature are examinations of the association between participation of consumer-run groups and utilization of inpatient facilities. A study by Burti et al. (2005) on inpatient psychiatric service users in Italy compared the costs of patients who were members of a self-help group with those who were not. The study found that those involved in a self-help group had a decrease in the number of hospitalization and length of hospital stay. The self-help participants were also found more

satisfied with work and education compared to non-self-help matches, who presented with more unmet needs (Burti et al., 2005). Besides reduced inpatient treatment, self-help groups have also demonstrated effectiveness in improving self-perception and social support for people suffering from psychosis. Castelein et al., (2008) investigated the effect of peer support group for people with psychosis on social network, social support, self-efficacy, and quality of life through a randomized controlled trial with 56 clients in the self-help group and 50 clients in the control condition. Their study found positive effects on social network and social support for those in the peer support group. Among the self-help group participants, those with higher attendance rate experienced higher levels of social support, self-efficacy, and quality of life (Castelein et al., 2008). Similar positive findings continue to be replicated in more recent self-help recovery literature. Findings from The Health and Recovery Peer (HARP) Program (Druss et al., 2009), a manualized, six-session intervention, delivered by mental health peer leaders for participants with serious mental health issues to become more effective managers of their illnesses, showed a substantial degree of improvement in patient activation. Patient activation is one measure of an individual's self-management capacity, which has been found crucial in guiding clinical care and predicting outcomes. For example, longitudinal studies have found patient activation strongly associated with improvement self-management behaviors, medication adherence, and outcomes such as quality of life (Mosen, Schmittdiel, Hibbard, Sobel, Remmers & Bellows, 2007).

Self-help groups and social functioning. Other studies have focused on the relationship between participation in consumer-run services and social functioning among people diagnosed as having serious mental illness. For example, Yanos, Primavera, and Knight (2001) found that people who participated in self-help programs presented with better social functioning in the community, particularly in the areas of coping effectively with symptoms, becoming more

hopeful, and gaining a greater sense of self-efficacy compared to those who did not participate in such programs. Feelings related to self-efficacy and empowerment appear to be some of the most frequent gains for individuals who participate in community peer support groups. Nelson, Lord, and Ochocka (2001) conducted focus group interviews with 59 stakeholders and in-depth interviews with six consumer/ survivors, finding that participants experienced an increased amount of empowerment and improvement in their social network through their involvement of self-help groups. Specifically, community self-help support groups seemed to serve as a medium for individuals to become more involved in community activities and forming meaningful connections with its members. In her personal narrative as a self-described psychiatric survivor and a user of peer-provided services, Deegan (2003) expressed that it "felt good [being] able to contribute some useful ideas that were heard and valued. I felt like a respected colleague" (p. 369).

Such opportunities to learn from the lived experience of people in recovery and their creativity in overcoming mental illness-related obstacles are rare. Deegan (2003) summarized one of the points that emerges from such studies and narratives:

> A small contribution to the history of recovery became a huge opportunity for personal development and for the ability to create opportunities for others as well… People in recovery and the mental health professionals working together can expand opportunities for recovery. The partnership also ensures that complex, individual needs and goals are not overshadowed by a "one size fits all" approach (p. 373).

Recovery and Self-Management

The term *recovery* is used in particular ways in the context of mental health treatment. Recovery has been described as "the amelioration of symptoms and other deficits associated with the disorder to a sufficient degree that they no longer interfere with daily functioning, allowing the person to resume personal, social, and vocational activities within what is considered a normal range" (Davidson & Roe, 2007, p. 461). Studies suggest that at least one quarter or even up to two-thirds of people diagnosed with a serious mental illness will achieve this form of recovery from the disorder and its effects (Davidson, Harding, & Spaniol, 2005). Another popular conceptualization of recovery in relation to mental illness informs that,

> The sense of recovery does not require remission of symptoms or other deficits, nor does it constitute a return to normal functioning. Rather, it views mental illness as only one aspect of an otherwise whole person….People may consider themselves to be "in" this form of recovery while continuing to have, and be affected by, mental illness. Recovery refers instead to overcoming the effects of being a mental patient—including poverty, substandard housing, unemployment, loss of valued social roles and identity, isolation, loss of sense of self and purpose in life, and the iatrogenic effects of involuntary treatment and hospitalization—in order to retain, or resume, some degree of control over their own lives. Given the traumatic nature of being treated as a person with a mental health condition, advocates have argued that return to a pre-illness state is impossible, emphasizing instead the gains the person has had to make to manage and overcome the disorder (Davidson & Roe, 2007, p. 462.)

Recovery-oriented mental health group organizations outside hospitals have been called "network[s] of caring and responsible people committed to assisting a vulnerable population

meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community" (Turner & Schifren, 1979, p. 2).

As the concept of recovery emerged from the mental health consumer movement in the 60's and 70's, people were permitted to be removed of the blame for the disease and be empowered to take control over their own lives (Humphreys & Rappaport, 1993). As described by Humphreys and Rappaport (1993), the initial phase of community mental health care movement focused on symptom control, remaining stable, and avoiding hospitalization. Up to the 1980's, mental health consumers challenged the notion of the chronicity of mental health – in other words, people with diagnosed mental illnesses were only "social problems because how a problem is defined is a prime determinant of the actions taken to resolve it and because studying how a problem gets defined can itself be a direct road to action and social change" (Humphreys & Rappaport, 1993, p. 893). The concept of *self-management* originated during this period from the community rehabilitation movement and within the medical rehabilitation and chronic disease literature. This term connoted people's confidence in their ability to manage their health and well-being despite diagnoses, treatments, and specific needs and changes over time (Lorig & Holman, 2003). Self-management programs provided interventions, training, and skills whereby people with a chronic condition, disability or disease can still effectively learn to care for themselves and navigate difficult situations.

Guided by the understanding that people with severe mental illness want and need more than symptom relief, community service shifted to the rehabilitation of the individual to fulfill societal roles such as a parent, spouse, worker, and student. Ralph and Corrigan (2005) profiled the recovery movement since the 1990s as focused on the pursuit of independence, self-management, personally meaningful activities, and better quality of life for people who have

mental illness. While clinical interventions assisted with symptom management and coping skills, community-based psychiatric rehabilitation services championed the idea of people leading competent and satisfying lives that are directed by own individual goals. Personal goals ranged from achieving independent housing, participating in educational and or vocational pursuits, developing better relationships with families and friends, and pursuing leisure activities. Evaluation of community-based treatment service programs found that comprehensive community support was correlated with fewer rehospitalizations and improved social adjustment. As a result, self-management programs have become more recognized and implemented to help people with serious mental illness gain knowledge and take actions that would help them feel better and benefit from positive impact with others (Ralph & Corrigan, 2005).

The successful implementation of community-based service systems derives partly from an emphasis on treating the consequences of the illness rather than just the illness *per se*. This perspective has shed light on configuring treatment delivery to focus on the total life impact of serious mental illness. The notion of recovery does not imply that all physical symptoms are removed, or "cured" and suffering is eliminated. Writings on recovery by service consumers/survivors/ clients in the psychiatric rehabilitation literature describe recovery as

> A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/ or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (Anthony, 1993, p. 527)

Similarly, Patricia Deegan, a psychologist who was diagnosed with SMI, explained that:

> Recovery is rediscovering meaning and purpose after a series of catastrophic events which mental illness is. It is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slick back, regroup and start again… The need is to meet the challenge of the disability and to reestablish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution. (Deegan, 1993, p. 57)

The consumer/survivor and psychiatric rehabilitation literature suggests that recovery from serious mental illness does not require full remission of symptoms or other deficits. Drake, Green, Mueser, and Goldman (2003) describe that recovery involves incorporation of one's illness within the context of maintaining hope about one's future, particularly about one's ability to rebuild a positive sense of self and social identity despite remaining ill. This process also involves overcoming the effects of being a mental patient, including (a) rejection from family, peers, and society as a whole; (b) poverty, unemployment, and substandard housing; (c) loss of valued social roles and identity; (d) loss of sense of self as an effective social agent and of the sense of purpose and direction associated with it; and (e) loss of control over, and responsibility for, one's major life decisions. Rather than leading the person back to a preexisting state of health, the processes by which people with serious mental illness achieve these components of recovery are ongoing in nature. As in other forms of trauma, these experiences change the person's life forever and may lead to growth or expansion of capacities in the process. Within this context, the person is able to pursue a meaningful and rewarding life of which the illness becomes a smaller and smaller part over time. More than that, the concept of recovery is capable

of holding the belief that people who have had a serious mental illness can still fully reclaim their lives despite continuing to have a serious mental illness diagnosis (Drake, Green, Mueser & Goldman, 2003).

Studying the Impact of Community-Based Treatment

As indicated, consumer/survivor and recovery-oriented services often take place in the context of community settings, and such settings often do not lend themselves to conventional research approaches (Smyth & Schorr, 2009). Community-based treatment emphasizes the process of systematic local exploration and cooperative inquiry to decide on the needs of community members; thus, a cooperative research element is comprised within community-based needs analysis and treatment design. In locating ownership among community members, community-based treatment challenges conventional paradigms, according to which any associated research would typically be conducted by academic researchers. Academic research that lacked collaboration with local community members would stand in opposition to these principles – and could also perpetuate the Western colonial belief that local knowledge of community members are unreliable (Smith, 1999). The application of conventional research paradigms to community issues can serve to perpetuate the exclusion of the perspectives of community service users from the research literature, obliging professional researchers to then "translate" the research outcomes back into community programs, practices, or policies and produce real-world effectiveness (Baum, MacDougall & Smith, 2006). Nevertheless, such community collaborations require psychologists and other professionals to move beyond the post-positivist research orientations in which many of them have been trained (Ponterotto, 2005).

Challenges and limitations to traditional experimental methods. A critical examination of psychology's penchant for objectivity and empiricism was influentially

conducted by Bakan (1967), an experimental scientist, who challenged methodological imperialism and the value of observation within the field. Bakan (1967) discussed the limitations of traditional forms of psychological research, the ".05 level of significance" to determine the psychological significance of the data. Bakan, in fact, saw experimentation as an abuse of psychology, which he termed "methodolatry," and that what is routinely considered to be objective data is itself not without bias (Bakan, 1967, pp. 94-95). Defending inferences made from more subjective data, Bakan argued that what may appear to be objective data is in fact highly determined and modified by the person observing it. The outcome of experimental research is ultimately a product, or an interaction, and a "teaching experience" that is co-created by the internal processes and motivating factors of the so-called experimenter and subject (Bakan, 1967, pp. 50-57). Thus, in the liberalization of methodology, Bakan suggests "careful and avowed use of introspection" in the research enterprise (Bakan, 1967, pp. 94-112), and to be aware of one's diversity and limitation in the examination of alternative positions in creating research (Lindauer, 1969).

Bakan's position of personal accountability with regard to subjectivity in research continues to be emphasized by authors today that challenge popularly-assumed requirements of the experimental design. Cautioning against the use of traditional experimental methods to determine the need and experiences of vulnerable populations, Smyth and Schorr (2009) argued that rather than diminishing the complexity and richness of real world experiences as nuisance variables, groups of people that are challenged by influencing systems must be seen in their real-world contexts, their interaction and relationship with communities, and be understood with all their challenges and strengths. Smyth and Schorr (2009) warned of the limitations of the experimental method, explaining that traditional experimental research, such as randomized

controlled trials, is still often used as the gold standard to evaluate programs that address the multiple realms of life of marginalized groups. The use of this experimental design is premised upon the belief that the methodology is pure, decisive, and flawless (Smyth & Schorr, 2009, p.11). Such methodology has shown effectiveness in delivering statistical relevance to some programs that have clearly circumscribed and measurable elements at an exact moment in time. The statistical outcome then may serve as the evidence-based result upon which funding structures base their financial decisions. Evaluations that employ experimental methods assume a linear, cause and effect relationship, much like experiments within a systematized, controlled laboratory setting. However, people, families, and communities living with sustained societal and political oppression and obstacles exist in a set of complex and intertwining system where experimental-design evaluation is a poor fit for social problems and risk factors.

At the same time, Smyth and Schorr (2009) pointed out that programs that emphasize an inclusive approach to address a broader range of information when making real-time judgments on complex issues are increasingly pressured to narrow their efforts to produce a small experimentally controlled range of evidence. Unfortunately, a constellation of experimental components does not necessarily add up to a proven whole, nor does it provide real-world effectiveness when reality calls for a rapid response to sudden crises or opportunities. Costly experimental-design evaluations also require extended periods of time and money to conduct and analyze. However, the lengthy evaluations are not necessarily up-to-date and only offer short-term change at best to the ever-evolving needs, strengths, and adaptations of communities. Essentially, evaluations that apply experimental conditions are a misfit for examining program interventions that need to address rich, dynamic, and complex factors of a specific context or community, especially for interventions that address complicated circumstances, such as the

intersectionality of poverty and other stressors – but they are relatively time-limited, cost-effective, and easy to conduct (Smyth & Schorr, 2009). Smyth and Schorr (2009) suggested a broadening of the evaluation paradigm to one that brings a more inclusive approach. Specifically, the authors argued for the use of additional methods, such as qualitative research methods and asking family and community participants to draw on their knowledge and experience to identify the systemic complexity and actions that are most likely to achieve the "outcomes that matter" and create positive and sustainable changes in people's lives (Smyth & Schorr, 2009, p. 20).

The arguments proposed by social science researchers such as Bakan (1967) and Smyth and Schorr (2009) directly challenge traditional ways of evaluating community-based interventions according to step-by-step, linear, quantifiable, "objective" data. Holistic community-based approaches to SMI recovery are likely to be among the interventions that are not well-suited to conventional study. Some researchers have proposed the use of Participatory Action Research (PAR), which is sometimes called Community-Based Participatory Research (CBPR), as an effective way of enhancing interventional relevance in the community, especially for complex social issues that affect and interact with the lives of community members and their health care (Davidson et al., 1999; Salzer, 2002; Mahone et al., 2011).

Participatory Action Research

Scholars have offered the use of participatory action research (PAR), also known as community-based participatory research (CBPR), as an effective systemic investigation that can facilitate reconfiguration of knowledge/power structures and the way these structures operate in community-based research (Hall, 1981). Like other types of psychological and psychiatric research, mental health research has typically been conducted by academic investigators,

whereas the functional unit of PAR is a community-academic partnership approach and the belief that all partners should be consistently involved in all phases of the collaboration. The following sections will describe the PAR process, the philosophical premises of PAR, and various PAR projects with diverse populations, outcomes, and results.

The PAR process. Instead of conducting research on subjects, PAR actively engages community members and other co-researchers that come together for the research topic or concern. PAR contrasts from conventional research as it calls for authentic participation. It is embedded in a tradition of cooperative inquiry that emphasizes working with community groups as co-researchers. The participatory approach assumes that the experts are the people who live the experiences that are being studied, and that knowledge is something that is produced through the active engagement and interaction of all members of a research group. In so doing, PAR strives to transform the social relations of research. This is often described as having an emancipatory or empowerment agenda, particularly as a tool for improving the lives of people with disabilities and from marginalized groups. PAR reflects an endorsement of the belief that the parties affected by the research should be engaged throughout the research process and have the right to affect the way the topic of concern is conceptualized, researched, practiced, and "brought to bear on the life-world" (McTaggart, 2009, p. 28). All participants must define together practical ways of participating; participation is thus a choice and not an imposition.

Notably, PAR "bridges the divide between research and practice" (Somekh, 1995, p. 340). It attempts to bring actual improvements in practice by eliminating a common two-stage process where research is single-handedly conducted by researchers and practice is solely carried out by practitioners. In PAR, the two-step process is combined, thereby broadening the traditional pattern that research and practice need to be two separate processes. Through the

continuous open dialogue, the research process becomes grounded in the values of the individuals and groups that are executing it.

Philosophical premises. Contemporary PAR emerged from a number of scholarly traditions. PAR draws on Lewinian philosophy of experiential learning, group dynamics, and action research (Lewin, 1935, 1936, 1948, 1951). Developed by Kurt Lewin during the post-World War II era, Lewin's action research perspective reflected his concern and experience with combating anti-Semitism, democratizing German institutions, and improving the position of women and the working class. These emphases led him to realize that local communities had the ability investigate their own realities and the ability to organize themselves to improve their conditions. To Lewin, experiential learning, group dynamics/ decisions, and commitment to action were necessary ingredients to achieving social equality. He also argued that individuals who would be likely affected by a decision should be critically informed and be the ones to test the results of the strategies being practiced. Furthermore, he posited that research must come hand in hand with the intersubjective meanings understood by those studying it, and thus would be acting in and on the issues that are being studied. With a critical, practical, and cyclical process of fact-finding, planning, action, reflection, and evaluation as central to its problem-solving process, Lewin's action research has been hailed for its educational component to the knowledge-building operation. More recently, action research has come to emphasize collaboration between workers and employers as well as individual, interpersonal, and group levels of analysis to collectively produce problem-solving strategies and improve organizational functioning (Brown & Tandon, 1983).

Other participatory scholars have emphasized the perspectives of marginalized people in the production and ownership of knowledge with the intention of defining realities and

mobilizing for action and change. This approach embraces an explicit political agenda. A crucial figure in the history of mobilizing action through a participatory approach within marginalized communities is Paulo Freire (1970, 1973, 1985), a Brazilian educator, who developed critical approaches to adult literacy education and supporting "individuals to identify and analyze their own problems and influence their own situations" (Sohng, 1992, p. 5). Freire (1970) popularized dialogical education that emphasized respect, cooperative inquiry, and social capital. He also believed that dialogue was a critical element of conscientization (critical reflection as essential for individual and social change). Furthermore, conscientization addresses a commitment to democratic dialectical unification of theory and practice. Freire saw conscientization as the counterhegemonic approach to the construction of knowledge within oppressed communities, and developing "consciousness that is understood to have the power to transform reality" (Taylor, 1993, p. 52). As such, many scholars acknowledge that Freire developed the intellectual component of PAR and paved the way to critical awareness through the cyclical process of action and reflection in the world of the participant.

Participatory action research is also grounded in feminist perspectives. Feminist participatory action research challenges the "outsider objectivity" with what Maria Mies (1993) called "conscious partiality" (p. 6), a practice that challenges the action researcher to understand the relationship between internal processes and external relationships on the status quo. Feminist research emphasizes shared power and seeks to empower individuals and communities in the research process to create social change.

PAR Projects and Outcomes

PAR, CBPR, and other participatory approaches have been used in a variety of settings to develop relationships with communities and to work closely with community locals to address

complex issues that are relevant to their everyday lives. The following sections will provide an overview of settings, populations, and issues in which a PAR methodology has been used to activate the knowledge and experience of marginalized populations, as well as to mobilize community support through a relational and united approach to address significant issues and discover more purposeful interventions.

Although PAR has been little utilized among applied psychologists, it has been conducted as multidisciplinary collaborations on issues related to mental health. In accordance to the underlying assumptions/ values of PAR, the methodology and results of these studies have taken on myriad forms that offered local importance and applicability as a result of alternatives to conventional research and intervention. For example, Schneider (2010) and her team of PAR researchers advocated for individuals diagnosed with schizophrenia and how they are treated differently by medical professionals compared to individuals with other diagnoses. The group members of the Unsung Heroes Peer Support Group for people with schizophrenia, all of whom have schizophrenia, and Dr. Barbara Schneider, a researcher from the University of Calgary, chose an open-ended interview approach to generate data on good experiences, bad experiences, medication, support, and diagnosis. Important aspects of the participants' experiences were integrated into the group members' theater performance. Furthermore, the results were developed into recommendations for medical service providers to make a difference for people who are similar to them and who will be treated in the future (Schneider, 2010).

PAR has also demonstrated its ability to be culturally grounded in research and community issues. In a partnership between university researchers and representatives of the Alaska Native community on creating, the researchers demonstrated important cultural considerations and community strength-based perspectives when examining the appropriate use

of qualitative and quantitative methods to look at sobriety and alcohol use in the community (Mohatt et al., 2004). Another PAR team of advocates and women survivors of interpersonal violence from nine ethnic communities (African-American, American-Indian, Latina, Filipina, Russian-speaking, Amharic-speaking, Cambodian, Vietnamese) and lesbian/bisexual/transgender (LBT) groups examined culturally specific ways of talking about domestic violence, women's experiences with services, how parenthood affects women's experience with domestic violence, and women's solutions for domestic violence through focus groups and interview-based methodologies (Sullivan et al., 2005). Together with research collaborators, the women survivors brought critical content expertise and experiential knowledge when examining and discussing ways of developing culturally relevant social support for women survivors of domestic violence, and presenting their work at local and international domestic violence conferences (Sullivan, 2005).

Similarly, in a youth participatory action research (YPAR) project, McIntyre (2000) partnered with inner-city youths to understand how the young students make meaning of their community, and how living in an urban area and attending an inner-city public school inform and influence their lives (McIntyre, 2000). Violence, the environment, education, and "becoming somebody" were key issues that the participants found important for them to examine. The participants opted for community photography to record aspects of their lives through their own perspectives, allow opportunities for others to see and increase their knowledge about the issues most affecting the participants' community, and to inform policymakers of a community's greatest pride and concern. The photographs were held in exhibits at the local school, community centers, and university setting and told powerful stories about the community and what needed to be done to enhance community life.

Community photography, or photovoice, has been used as an effective PAR methodology to promote critical dialogue and knowledge and address homelessness issues. In a participatory action research movement by Wang et al. (2010), the men and women living at a shelter in Ann Arbor, Michigan, were the researchers who documented their everyday health, work, and life conditions to bring awareness to policymakers and broader public about issues that homeless people are subjected to live with. The important and thought-provoking photographs taken by the participants were exhibited at the city's largest theater and attended by invited city council members, practitioners, and the public who were interested about the impact of photovoice on participatory health promotion aims, settings, and issues (Wang, Cash & Powers, 2000). Krieger et al. (2002) also successfully mobilized the attention of policymakers in a PAR project comprised of community agencies, activists, public health professionals, providers, and academics on issues of public health and safety. In their study based in Seattle, Washington, numerous community organizations (such as the Center for Multicultural Health, the Community Coalition for Environmental Justice, the Seattle Tenants Union, and the Washington Toxics Coalition) partnered with the Health Department of Seattle and university faculty members to examine the impact of housing issues on the community's health, the local resources, cultural values and beliefs, and awareness of the feasibility of safer housing quality for individuals with asthma. The partnership between health workers and participants was able to tackle issues such as controlling pests and making repairs in the homes. Furthermore, the research team secured a government grant to examine structural remediation of substandard housing units to minimize health related hazards.

Results and outcomes of PAR. The PAR process opens up alternative ways of thinking about and perceiving the world while fostering a space for shared reflection in which knowledge

is created, interpreted, and acted on by those who make up the communities of concern (Mohatt, 2004). Therefore, the outcomes of PAR studies can naturally look very differently and take on many different formats depending on individual methodological approaches and the different issues of concern. The research outcome interpretation and dissemination process also vary depending on the goals and objectives of the co-researchers. PAR participants can select on a wide range of communication strategies that do not fit neatly into traditional methods for publishing academic research, as their target is not necessarily scholarly journals. Generally speaking, PAR collaborators join together in solidarity to take both short and long-term collective action to create social change (Hall, 1993). Furthermore, the social change is aimed at integrating research and intervention in order to minimize the polarity between knowledge and action. For example, weekly discussion periods on issues of interpersonal violence conducted by PAR co-researchers have created safety resources and support for female minority survivors such as developing first-language educational and social support groups that allowed group level problem solving and cultural activities (Sullivan et al., 2005). A PAR project can even represent the journey of working through a contentious history between institutions (and their representatives) and local communities. In a study by Mohatt et al. (2004), professional researchers teamed with Alaska Natives to look at alcohol abuse prevention and treatment. Critical issues related to the tensions between indigenous values and ways of knowing and Western research methodologies were discussed, thus offering an opportunity to all participants to engage in culturally-anchored participatory teamwork (Mohatt, 2004).

PAR projects can also feature very creative, yet informative, formats. In a study by Schneider and her co-researchers looking at the experience of people diagnosed with schizophrenia, the participants – who included members of the Unsung Heroes Peer Support

Group for people with schizophrenia, all of whom have schizophrenia, and Dr. Barbara Schneider, a researcher from the University of Calgary-- engaged in various activities to reach beyond the academic forum. For example, their dissemination process included creating readers' theater performances, which is a minimalist style of theater with no staging or costume and scripts are used openly in performance. Furthermore, the researchers created a graphic novel version of the material in addition to producing DVDs that captured the messages derived from interviews with the group members (Schneider, 2012). Another PAR project examined the impact of housing quality on people with asthma (Krieger et al., 2002). Conducted by a multidisciplinary team of health workers, governmental agencies, university researchers, and community representatives, the collaboration was able to tackle issues such as controlling pests and making repairs in the homes, in addition to receiving funding from the Department of Housing and Urban Development to conduct and evaluate structural remediation of substandard housing units.

While the results and outcomes of PAR projects can vary widely, PAR projects ultimately intend for research team collaborators to bring together critical content expertise and experiential knowledge to the development of culturally and locally relevant changes and recommendations that benefit the constituents of the communities in a meaningful way (Sullivan, 2005). In many of the aforementioned studies, the results were presented to various audiences at the community, university, national, and international level. Some common outcome experiences expressed by PAR co-researchers are: unexpected increase in self-esteem, feeling "important and useful" with the opportunity to define life as the participants understand it, increased curiosity and awareness in their own surrounding, inclination to imagine the world from another person's

point of view (Wang, Cash, and Powers, 2010), and creating bonds and friendships that run beyond the scope of the research question.

PAR and Diverse Populations

Given its emphasis on empowering marginalized social groups, it is not surprising that PAR has been considered a relevant, effective approach for work with diverse ethnic and cultural populations (Stacciarini et al., 2010). As PAR offers an opportunity for community representatives to collaborate in the identification of a research problem, the analysis of the data, and the application of the findings in a meaningful way, it is a well-suited approach for understanding different worldviews and honoring subjectivity and reflexivity emerging from environmental and social contexts. For example, an aspiration to address the larger sociopolitical and economic structures that influence wellbeing was demonstrated by Lantz et al., (2001) in their collaboration with the east and southwest sides of Detroit city, areas that contain primarily African American and Latino communities. Through a collaborative effort to recognize the relevance of local public health problems within an analysis of the social, economic, and cultural conditions that influence health status, the co-researchers accomplished a wide array of successes, ranging from identifying funding sources, publishing manuscripts, and presenting to numerous audiences. Moreover, the co-researchers of the project found their collaborative relationship to be "cohesive," "strong," and "candid" (Lantz et al., 2001, p. 500). Trusting relationships had been built on personal and organizational levels between community members. Community agencies, and university researchers, thus lending meaningful and authentic collaboration as well as an "extremely positive consequence… a partnership attempting to work across cultural and community differences." (Board member of Detroit Urban Research Center, Lantz et al., 2001, p. 502).

As mentioned earlier, PAR has been successful as a research practice and intervention for use by communities that may be alienated from the larger Western societal context in which they are embedded. For example, Mohatt et al. (2004) demonstrated the use of PAR to challenge the reinforced oversimplification of theory and stereotypes regarding Native peoples and alcohol consumption. In this PAR collaboration with Alaska Natives, the co-researcher team found a way to develop their research questions and navigate the data through a culturally anchored, interdependent and collective way of understanding an individual's journey with sobriety. The partnership yielded a rich interpretation of the data that served as an important jumping-off point for developing a quantitative measure with attention to cultural methods of gathering accurately relevant information. Deeper levels of inquiry were made possible through PAR when community representatives with different roles and expertise shared the responsibility of the inquiry in a reciprocal and reflective process. The co-creation of knowledge and co-experience of power-sharing in PAR was experienced as one co-researcher puts it, "*Ellam-iinga*," the process of becoming aware (Mohatt et al., 2004, p. 272).

This process of becoming aware was experienced in another PAR project by Stacciarini (2008) and Puerto Rican female mental health workers to develop and implement an effective and culturally appropriate intervention for Puerto Rican women with depression. Specifically, they examined the cultural appropriateness of certain interactive activities in their community-based intervention while identifying significant cultural relevance in relation to them (Stacciarini, 2008). In the process of becoming aware, the focus groups employed in this PAR study brought to light significant cultural values and beliefs, as well as culturally appropriate planned interactive activities. Specifically, it was found that activities that were considered a "healthy alternative" to treatment must consistently allow for "group effort" to emerge and be

comprised of a sense of "togetherness" for Puerto Rican women recovering from depression (Stacciarini, 2008, p. 692). Another PAR project that examined the need and cultural appropriateness of community-based services was one conducted by South Asian women living in Windsor, Canada. The South Asian Centre (SAC) collaborated with 25 South Asian women to examine the issues and problems associated with balancing work and family in the Windsor-Essex County community (Cassano & Dunlop, 2005). Weaving in a focus group methodology, the collaborative endeavor resulted in the South Asian community identifying problem priorities and providing recommendations to the SAC regarding developing programs for seniors and children.

PAR's principles are premised on ensuring mutual trust and respect by recognizing the cultural needs of a community as the locals understand them. These values are illustrated in Dong, Li, Chen, Chang, & Simon's (2013) collaboration with Chinese community leaders and stakeholders on the use of community health education workshops to enhance knowledge of specific health topics among Chinese older adults in Chicago. The partnership involved creating a community advisory board comprised of community leaders and stakeholders from various organizations who helped identify workshop topics. The project found that knowledge of and respect for the community's cultural values and population needs were essential to the success of the workshops. For instance, the workshops were implemented in the Chinese participants' dialect of preference and participation was encouraged in ways that were no 'authoritative or making them feel as though they are "losing-face"' (Dong et al., 2013, p. 178).

Epstein et al.'s (2007) collaboration with African American churches in creating substance abuse prevention projects for young Black women is another prime example of deliberate inclusion of community values and local culture for successful community

partnership. The project was initiated by the Missouri Institute of Mental Health (MIMH) with a three $1 million three-year grant from the Substance Abuse and Mental Health Services Administration. The goals of the project were to implement faith-based gender specific integrated HIV/AIDS and substance abuse mentorship for African American girls in the St. Louis metropolitan area, in addition to developing a rural faith-based methamphetamine and inhalant prevention research initiative that would include professional software and video elements. The project outcome was not yet fully realized in the published manuscript but the CBPR process has established a pattern of open and frequent communication for all team members' to provide input on tailoring interventions that are rooted in African American spirituality and culture, which created an opportunity where the final product will be richer in meeting the divergent needs of all parties (Epstein et al., 2007). These studies are but a few studies that point to the effectiveness of PAR in its emphasis on partnering with diverse and vulnerable communities to create an alternative to traditional research that is grounded in equality, action, change, and focus on benefiting the community involved.

Participatory Action Research and Serious Mental Illness

Participatory methods have been used with people with serious mental illness (Schneider et al., 2004; Truman & Raine, 2002; Davidson, Stayner, Lambert, Smith, and Sledge, 2001; Walsh & Boyle, 2009; Nelson, Ochocka, Griffin, & Lord, 1998). In the work of Chamberlain, Rogers, and Ellison (1996), the authors partnered with a consumer Research Advisory Board comprised of ten consumer individuals to develop survey instruments. These instruments were designed to correspond to the characteristics of members of self-help/mutual aid organizations and were planned for use in collecting data on the effect of user-run programs as perceived by members. The authors argued that the use of a research advisory committee fulfilled the requisite

that constituents of the research must be involved in the research process for the evaluation to be meaningful and credible. The survey developed by the Research Advisory Board collected information about members' demographics, length of involvement at self-help programs, perceived quality of life, self-esteem, social supports since participating in self-help, and satisfaction with their current program. Although the questions were derived from pre-existing scales, such as quality of life and self-esteem measures, the Research Advisory Board decided to select survey questions to minimize potentially threatening perceptions of extant instruments rather than use standardized psychological assessments. Additionally, the group created a separate questionnaire to obtain descriptive information about the programs. The Research Advisory Board recruited members from six self-help program agencies to complete the survey questions. Participants indicated that "being involved in self-help had a salutary effect on their quality of life, including their general life satisfaction" (Chamberlin, Rogers & Ellison, 1996, p. 40). This study demonstrated the effectiveness of a research steering committee that has substantial consumer/survivor membership to ensure that consumer/ survivors' voices are amplified and enabling a PAR spirit to emerge more fully.

Similarly, McDaid (2009) engaged with a group of co-researchers who attended a community-based gym that was built for improving the physical well-being of people with serious mental health problems. McDaid used cooperative methods of working, such as deploying focus groups as a platform by which all participants could begin collaborating as equals through sharing power and deciding on a research question that was more relevant and meaningful to consumers. The chosen research topic concerned the delineation of successful volunteer involvement within the facility (McDaid, 2009). The group explored satisfaction in the role of the volunteer, barriers to meaningful participation, and recommended ways to sustain

involvement that supported users to recognize their existing skills, develop new ones, and at a pace that was compatible to particular circumstances and personal resources (McDaid, 2009).

In Hearing (our) Voices, a project carried out by mental health service users diagnosed with schizophrenia (Schneider, 2012), the participants researched the topic of interactions with medical professionals because they had a sense that they were treated differently than patients with other illnesses. They employed a survey method and engaged in data analysis that included categories of good experiences, bad experiences, medication, support, and diagnosis. The results were developed into recommendations for their medical service providers. After their first successful research implementation, the members of Hearing (our) Voices executed a second project on the topic of housing for people diagnosed with schizophrenia. Their confidence as researchers has enabled the group to employ more complex research methods such as doing focus groups and interviews with people in the community (Schneider, 2012).

PAR as Socially-Just Mental Health Practice

In each of the PAR project described above, the collaborations were developed via power-sharing conversations on critical issues relevant to community members, privileging the voices of community members, fostering connectedness and supportive relationships, and providing information and tools to enable community members to carry out research, take action, and strive for social and practical change (Nelson et al., 1998). These examples honor what Patricia Deegan called "the conspiracy of hope" (Deegan, 1996). In her words,

> Our task is not simply to pass judgment on whether someone will recover from mental illness, or whether they are likely to overcome the devastating consequences of poverty, stigma, dehumanization, degradation and learned helplessness. Our challenge is rather to participate in the "conspiracy of hope."

> And it is our task to create a "community of hope" for people with psychiatric disabilities, to create, in other words, an environment that offers possibilities for further development. It is our task to convey the spirit of hope to mental health teams. We need to ask people with psychiatric problems what they would like and what they need in order to grow, and to provide them with fertile ground where new life can take root. And finally, it is our task to be patient, observe with suspended belief and bear witness with respect, how the life of another human being can unfold. (p. 8)

PAR has the potential to enhance psychological well-being along the lines that Deegan conveyed. As such, PAR can be seen not only a research methodology but a psychologically growthful process in and of itself. Through the participation of the people-for-themselves, the value of empowerment and inclusion is exercised as people's voices are heard and their choices are expanded. Empowerment can then be experienced not only through gaining and creating knowledge but through the fostering of connectedness among the research team. PAR emphasizes giving power back to communities by identifying existing strengths and potentials, community capacity building, and co-learning among members of a community. The partnership between those who are marginalized and those who are often in power can develop into a democratic process in which issues that were unknown, overlooked, or ignored by outside "experts" are named. Accordingly, the power to make critical decisions and the agentic role in the creation of knowledge is reverted to members of communities that are traditionally ignored or exploited (Smith, Davis, & Bhowmik, 2010). Beyond producing relevant research, the intricate interpersonal process of mutuality and power-sharing that characterizes the PAR

journey can have profound personal and interpersonal effect on community and university co-researchers (Smith, Bratini, & Appio, 2010).

PAR has the potential to allow participants, therefore, to be liberated from the necessity to merely reproduce the worldviews, values, and interests of dominant groups. Fals-Borda (1991) specified this as a distinguishing feature of PAR: that the power-sharing experience is a transformative process for the researcher/researched, subject/object liaison in which each can be freer of oppressor/ oppressed roles. Furthermore, there is a privileging of local voices, local culture, and local wisdom in this journey of "autonomy and identity in collective research" that is emancipatory and transformative on broader levels of social change (Fals-Borda, 1991; Brydon-Miller, 1997; Maguire, 1987; Lykes, 1997). The sharing of power with people is also what Deegan (1996) argues for as she describes a society that has been historically oppressive for people with mental health problems. As described by Smith, Bratini, Chambers, Jensen & Romero (2010), entering the PAR journey no longer confines the participants and protects the researchers by clinical detachment of conventional training but instead challenges all to swim in a sea of challenges, questions, and confusion from the different kinds of entities that community members and outside researchers represent. And instead of making judgments about what is "in the client's best interest," PAR teams can instead ask clients what they want for their own lives and then provide them with the support to achieve it (Deegan, 1996, p. 10).

Some of the evidence that PAR contributes to the well-being of participants has come from the words of co-researchers themselves. PAR contains various process-related dimensions. In a focus group conducted between a faculty member and a doctoral candidate with a group of women in a poor urban community on the experience of PAR, a member described the personal change from the impact of PAR as such:

> When I do research into the community, when I do research and I find out what people need, what people don't have, what people have, and then put myself in a position to be able to offer something, it makes me feel so good, it makes me feel lighter… Lighter means less baggage. (Smith & Romero, 2010, p. 19)

The experience of personal change and empowerment is also documented by Torre and Fine (2005) in their PAR project with incarcerated women where they evaluated a college-in-prison program. One of the co-researchers summarized her experience as:

> Being able to exchange ideas and learn new ways of life, and learn about the classics… I sort of started identifying with the world, understanding the world better; understanding… my crime and why I was here… I just wanted to read everything… I wanted to know more, I wanted to explore. When I started going to college that was like the key point for me of rehabilitation, of changing myself. And nobody did it for me, I did it for myself. (p. 582)

In relation to taking action through the knowledge dissemination process, one member of the Unsung Heroes group described,

> This was quite an experience for our group. We were all very nervous. We did our presentation twice in one day. The conference was large; the audience was all people interested in schizophrenia. There were medical professionals, representatives from drug companies, family members, researchers, and on and on. We presented in the latter half of the day in workshop-type format. After we did our presentation and recommendations, we broke the audience up into smaller groups. We then went into the audience and talked with them. For me the whole experience was very empowering, as it put me on a level playing field with

> persons who oftentimes had power over me. I felt heard where it might make a difference someday in the treatment of people suffering from schizophrenia. To top it all off the experience was fun…. and met people from all walks of life. (Schneider, 2012, p. 159)

PAR and People with Mental Illness: Summary

This chapter has thus far examined serious mental illness, the evolution of mental health treatment, the challenge of gaining personhood with a serious mental health label, and the right to experience equity and empowerment during the recovery process through community-based approaches and other initiatives that feature social justice elements. We saw that the impact of community-based treatment movement has been considerable, especially in challenging traditional and deficit-based assumptions that have governed treatment; culturally syntonic alternative interventions, including PAR, were presented as alternatives. The theoretical foundation and historical evolution of the PAR methodology were summarized, along with its use and outcomes with various settings, needs, and populations, including people with serious mental illnesses.

Complementary trends within the treatment of serious mental illness have emerged directly from the multicultural movement in applied psychology, particularly counseling psychology. With regard to people marginalized by psychiatric labels, Ivey (1973) argued that part of treatment should be advocating for, promoting, and working with clients as change agents in the society that relegated them to the psychiatric setting. Ivey and Collins (2003) also described the role of the counseling psychologist as an activist change agent and that:

> It is virtually impossible to solve some individual problems if the context in which they occur does not change. If social conditions of societal

> underemployment and unemployment, unfair distribution of income, and oppression continue, counselors and psychologists will continue to work with victims of "the system. (p. 291)

Although Ivey (1973) illustrated the application of multicultural competence to the stigmatization of mental illness, multicultural psychologists are best-known for their attention to diversity according to race and culture – and at this point, the notion of intersectionality will be introduced with regard to mental illness stigma and racial-cultural marginalization. Cole (2009) described intersectionality as a feminist perspective according to which the operations and consequences of multiple social group memberships could be examined. In particular, this review will incorporate consideration of the meaning and treatment of mental illness within the historically rich Chinese culture. The coming together of diverse and rich cultural values and their influence on psychological treatment will be explored in the following section. Specifically, the section will provide an overview of the current demographics of Chinese individuals in the U.S., prevalence of mental illness, and utilization of service intervention for mental health issues.

Chinese Communities and Mental Illness

Culture influences the perceptions, descriptions, and interpretations of meanings, causes, and effects of mental illness, and as such, clinicians have recognized the need to match their conceptualizations and treatments with the diverse cultural identities of a client (Sue & Sue, 2013). Researchers have identified a positive link between treatment adherence and working alliance when a correspondence is achieved between clients diagnosed with a serious mental illness and their service providers (Constantine, 2002; Vasquez, 2007; Zane, Sue, Castro, & George, 1982). In fact, an APA Presidential Task Force (2006) defined evidence-based practice in psychology as “the integration of the best available research with clinical expertise in the

context of patient characteristics, culture, and preferences" (APA Presidential Task Force, 2006, p. 273).

With regard to Chinese clients, the client-therapist match may involve such elements as cultural beliefs and attitudes around morality in Chinese, how these attitudes shape explanatory models for mental illness, cultural influences on symptom presentation, interpretations of meanings and causes of illness, decisions regarding help-seeking, and/or compliance with prescribed treatments (Kung, 2004). Finally, these elements will be considered alongside earlier themes in an exploration of the application of PAR as an alternative intervention for Chinese individuals with serious mental illness. As these themes are explored, the emphasis will be upon Chinese immigrants to the U.S. (who may or may not be naturalized American citizens) and their children (who may or may not have been born in the U.S.). As there is little extant research that focuses precisely and narrowly on this population, coinciding literature will be reported regarding Chinese Americans (who include descendants of families who have lived in the U.S. for any number of generations) and/or Asian Americans (who include individuals of other Asian ethnicities). Terminology will, therefore, vary in keeping with the original authors' usage.

Demography of Chinese in the U.S. and mental illness. According to the U.S. 2011 Census Bureau, Chinese immigrant families make up about 22% of the total Asian population in the U.S. The Chinese constitute the largest percentage of the Asian American population (U.S. Census Bureau, 2011). According to the 2011 U.S. Census Bureau, China (including Hong Kong, Macau, and Taiwan) accounted for the majority of foreign-born from Asia. Despite the number of Chinese people residing in the U.S., limited studies have explored the subjective experiences of Chinese American immigrants with serious mental disorders. In recent data collected from the National Latino and Asian American study, Asian Americans have a 17.30

percent overall lifetime rate of any psychiatric disorder and a 9.19 percent 12-month rate (Alegria et al., 2004). Chinese Americans have been estimated to have the highest lifetime prevalence rate of depression among Asian American groups (Kessler, 1994). Chinese Americans show higher suicide rates than do same age-gender groups in other ethnic communities. The rate is found to be even higher for foreign-born Chinese Americans as compared to American-born Chinese Americans. There is currently no data on Chinese ethnic groups in the U.S. and schizophrenia prevalence. According to the National Institute of Mental Health (NIMH, 2011), schizophrenia affects 1.1 percent of U.S. adult population annually (Phillips, Yang, Li, & Li, 2004). The prevalence of schizophrenia in China is 1.77 percent, with higher rates in women than men. However, Asian Americans are three times less likely to seek mental health services than Whites (Matsuoka, Breux, & Ryujin, 1997).

U.S. Chinese and mental illness service utilization. As indicated, the mental health needs of the Chinese ethnic population remains one of the least understood U.S. ethnic minority groups despite its growing numbers. At the same time, Chinese Americans live in the context of systemic racism, cultural oppression, and discriminatory practices such as Chinese Exclusion Act of 1882, where for the first time, Federal law barred the immigration of a particular nationality for a period of 10 years, based on the belief that "Chinese laborers to this country endangers the good order of certain localities" (U.S. Statutes at Large, Vol. XXII, p. 58 ff). The Geary Act in 1902, which extended the exclusion of Chinese laborers for another ten years and stripped most legal rights from Chinese immigrants (McKee, 1977). Similarly, the Immigration Act of 1917, was passed to increase the banning of certain groups and populations. A section of the law designated an "Asiatic Barred Zone," a region that excluded immigration from most of Asia (Lee, 2003, p. 39). Finally, the Magnuson Act of 1943, which allowed Chinese immigration for

the first time since the Chinese Exclusion Act of 1882, was passed the year China became an officially allied nation to the U.S. in World War II. Although it is often considered a positive development between the two nations, the number of Chinese immigrants allowed into the U.S. was disproportionately low in ratio to the sanctioned immigration of other nationalities and ethnicities (105 arrived per annum instead of the quota of 2,150 per annum) (Wei, 2007). This history of intergenerational racism may foster the mistrust of Western and/or American service providers, contributing to underutilization of mental health service.

Along these lines, Asian Americans have been found to underutilize mental health services compared to other racial groups, although they experience just as much cultural conflict, racism, and generational conflict as other racial-cultural groups (Abe-Kim, Takeuchi, Hong, et al., 2007; Leong, 1994; Atkinson & Gin, 1989). Spencer and Chen (2004) found that experiences of discrimination resulting from speaking a different language and having an accent were important stressors that prevented the use of conventional mental health services. The authors supported bilingual and bicultural services as a means for providing culturally sensitive services to Chinese Americans who may experience discrimination from lack of English-language proficiency. The authors further suggested that capitalizing on the common practice among Chinese Americans to seek help from the community by developing positive social networks in community-based support groups.

Interestingly, in a more recent study of Asian-American health-seeking behavior by Spencer et al., (2010), the authors found that language barriers and negative stigma surrounding mental health issues continued to be the biggest deterrents for seeking professional health care. Similarly, support from personal networks, such as members of the community, was found to be the main avenue for help-seeking behavior. Other researchers also emphasized the need for more

bilingual services and more collaboratively health services and community resources (Lee et al., 2009). Furthermore, with most of their relatives in their native land, many Chinese immigrants find it difficult to rely on the help of family members to deal with mental illness (Lam, Chan & Leff, 1995; Kung, 2004). With limited family support, underutilization of traditional mental health treatment, and fewer resources specifically applied to this ethnic minority group in general, Chinese families seem to face a unique set of needs.

Chinese cultural values. The Chinese cultural conceptions of the person are relational in nature (Hsu, 1985; Zheng & Lin, 1994), and as such, privileges interpersonal bonding over individualism (Lee, Lee, Chiu & Kleinman, 2005). Chinese culture also considers interpersonal and intrapersonal harmony as an important condition to a state of well-being (Kung, 2001), and disturbance in individual functioning is often attributed to disharmony with others (Lam et al., 2010; Tseng, 1975). Especially relevant within the mental health literature appears to be the cultural value placed upon maintenance of face and harmony (Atkinson & Gim, 1989; Lam, Chan & Leff, 1995; Kung, 2001, 2004). As will be described below, the motivation to maintain face for the sake of harmony may push an individual or family's preference to minimize or deny the existence of mental illness or carefully guard against its disclosure to people beyond the nuclear family.

Face and moral standing. Yang and Kleinman (2008) presented a conceptual model of how the Chinese cultural phenomenon of *face* represents a person's moral standing in the community and interacts with the stigma of schizophrenia. A respected individual "has" face and "receives" face. The "giving" of face represents observable respect for another (Yang, Kleinman, Link, Phelan, See & Good, 2007). In illuminating the cultural links of mental illness social stigma, the authors argue that at the heart of stigma is a moral process that impedes a person's

face-giving and receiving ability to mobilize resources and social capital to gain status in one's community. Specifically, in Chinese society, morality is experienced through interpersonal relations that are bound with Confucian values that are transmitted through everyday education and social interactions. The moral rules informed by everyday educational and interpersonal processes organize a "web" of human relationships that uphold obligations and all the actors' statuses. Confucian beliefs hold that in order to be a complete citizen of a community, a person must participate in reciprocal familial obligations and achieve cultivation through education. The long Chinese tradition of academic aspirations for children dates back to the Mandarin system where people from poor villages achieved status through public examinations to become a government official. Family reciprocity is achieved when parents produce offspring who can continue the lineage and when children perform filial obligations, such as providing a lifetime of economic and social support for their parents, whereby "an eternal chain of filial children" is achieved (Stafford, 1995, p. 86).

Another part of achieving moral cultivation is developing self-restraint. This cultural belief maintains that by practicing self-control and adherence to rituals, keeping the self in order (such as controlling and keeping good social networks within family ties), the state and the entire world (classmates, friends of friends, and people from the same region) can be in order. Accordingly, everyone in the interpersonal web internalizes and adheres to their obligations, thus supervising and regulating not only their own actions but also the actions of others (Yang et al., 2007).

Face and mental illness. Although Chinese cultural values prescribe a tightly-knit family group, mental illness may cause distance between a person with an illness and kinship support. The belief that a person with mental illness is deficient and unable to achieve familial

obligations, such as continuing lineage and gaining social capital by fostering connections that can mobilize resources for members within one's capital, is perceived as neglectful of the family and other social obligations. The inability to live up to social expectation is considered to be immoral and to cause a loss of face (Lee, Lee, Chiu & Kleinman, 2005). A person that loses face experiences shame (Lee, Lee, Chiu & Kleinman, 2005, Yang & Kleinman, 2008). In Chinese culture, shame is believed to be the primary effect that drives a person to fulfill social obligations in order to prevent an intense dread that can be felt more strongly than physical danger (Lau, 1984; Hu, 1944). Since an individual represents not only themselves but the close networks (family and associates from the same region) where all previous social exchanges were aimed to cultivate moral behavior, a person who loses face ends up placing themselves and their affiliates in a disadvantaged position with regard to resources and relationships for themselves and each other. As Yang et al. (2007) described,

> When Chinese experience loss of face, they quite literally report the experience of humiliation as an inability to face others, as a physical crumbling of facial expression, a way of being faceless… [It is] a fully embodied, physical, and affective process that takes place in the posture, positioning, and sociality of the sufferer. (p. 1530)

The person who loses face or moral standing is deemed despicable and becomes isolated. The social respect and resources are withdrawn and means of access are excluded. In this respect, the loss of social standing and weakening of social ties lead to feelings of overwhelming shame, humiliation, and despair. The same negative internal feelings can also drive a person's social distancing from the public and social obligations, thus further perpetuating the perceived lack of moral character in the individual (Yang & Kleinman, 2008).

Moral standing and mental illness. Based on the value of achieving cultivation through individual restraint, the perceived lack of ability to control oneself renders a person as "not fully cultivated and thus incompetent to participate in social life" (Yang & Kleinman, 2008). As a result of this perceived lack of moral standing and thus the incompetence to participate in local exchanges as fully cultivated adults, individuals with mental illness are often relegated to lower positions expressed through infantilizing responses (Yang & Kleinman, 2008). This phenomenon is demonstrated in studies on mental health service providers' perception of mental illness in China. In a study by Sevigny, Wenying, Peiyan, Marleau, Zhouyun, et al. (1999) using a sample of psychiatric hospital nurses in Beijing, 63% endorsed the belief that individuals with mental illness need to be treated like children. Treatment of patients at psychiatric hospitals has in fact included singing songs and dancing like children (Pearson, 1995). The Confucian ethic also dictates the ability to exert control over oneself (Lau, 1984). The occasional disruption of social order and the failure to act in ways that promote social harmony are considered serious transgressions of social norms in the Chinese worldview (Kleinman, 1997). With the deeply ingrained belief that people with mental illness act dangerously and unpredictably (Phillips & Gao, 1999), people with psychiatric illness can be thought to exhibit "moral bankruptcy" and are without status as fully adult citizens of their community. Thus, face serves as a crucial determinant to the utilization or the inclusion of external help such as mental health services. While restricting information about the illness strictly within the family can serve a protective factor, it may also cause an increased burden for the family members and isolation from potential sources of help. Given the common constraints experienced by immigrants who must establish new grounding in a foreign country, traditional talk-therapy may not, therefore, be viewed as a fitting tool for their lives. Rather, Chinese families may prefer a more goal-directed and

pragmatic structure where clear and realistic goals and objectives can be openly discussed. The preference for addressing practical matters in the context of establishing new social, occupational, and functional prospects may require therapeutic models to be more specific and problem-solving oriented rather than open-ended (Kung, 2003, 2004).

Stigmatization and Chinese cultural values. The literature on stigma also contributes to understanding the impact of mental illness on Chinese individuals, whose wellbeing relies heavily on social perceptions of face and the relational networks that maintain or impinge upon face. Yang, Kleinman, Link, Phelan, See and Good (2007) outlined that cognitive, affective, and behavioral processes interact and produce an individual's stigmatized social identity, which is understood to be the result of individual, interpersonal, and societal processes that construct a devalued social identity within a social context. Individuals with a stigmatized identity must actively cope with the feedback and assessment through cognitive strategies of the stigmatizing situation. Goffman (1963) conceptualized stigma attached to mental illness as "moral career" (p. 32). As part of this "career," a stigmatized person initially learns and internalizes a society's standpoint and the general understanding of what it means to possess a particular stigma. A person with mental illness realizes that they fall from a "normal" to a "discreditable" status -- and ultimately, a "discredited" status if the illness is discovered. Stigma contains structural components that move beyond the interpersonal level and arise from economic, political, and historical sources (Corrigan, Markowitz, and Watson, 2004). Powerful institutions can intentionally implement policies that limit the opportunities of stigmatized people (e.g., state legislatures restricting people with mental illness from voting), and thereby prevent people with a stigmatized identity from engaging fully in society. Thus, stigma can potentially disrupt a

person's participation as full citizens not just in their local environment, but also on large institutional levels.

Mental illness stigma and moral experience. Yang et al. (2007) offered a comprehensive formulation of how stigma threatens the moral experience of Chinese individuals and groups. Stigma moves quickly from individual to kinship ties, a structure in which all players are expected to maintain and prosper. With the etiological belief that a person with mental illness is assigned with "moral defect" (Yang & Pearson, 2002), family members suffer from intense stigmatizing attitudes that are not only directed at the member diagnosed with the mental illness. Bringing stigma to the entire family threatens the vital connections of a person's support, resources, life chances, material and social opportunities for the family structure to prosper. Lee, Lee, Chiu and Kleinman (2005) found that perceived stigmatization and anxiety over disclosure have caused significant distress for patients diagnosed with mental illness. Among their sample of 320 out-patient participants with schizophrenia, approximately 41% deliberately avoided social contacts, and about 44% had considered suicide. To avoid public shame and marginalization, many family members and the person with the illness reported concealing the mental illness to prevent shame that is not only taken on by the patient but their families as well. Thus,

> stigma is most grievously felt as its conditions reverberate across social networks, such that both the entire network is threatened or devalued and the individual sufferer is shunned, banned, or discriminated against within that network as a defensive response. The end result for individuals with mental illness and their families in China can be a kind of social death that threatens the very existence, value, and perpetuity of the family group. (Yang et al., 2007, pp. 1529)

More specifically, Yang and Kleinman (2008) have conceptualized mental illness stigma as a social mechanism that is influenced by the interpretive engagements of social actors, involving cultural meanings, affective states, roles, and ideal types within a person's local world (i.e. social network, a neighborhood, a workplace setting, or an interest group). By engaging in lived experiences of "what matters most," moral experiences emerge from practical everyday social engagements of the things that are considered most at stake (e.g., status, life opportunities, money, relationships, a job, etc.) (Yang & Kleinman, 2008). Accordingly, people with serious mental illnesses are restricted from achieving major milestones of what is most at stake in life, such as marriage and employment. Accordingly, the unemployment rate of people with schizophrenia in China is only half that of their age group, are twice as likely not to get married, and have divorce rates that are approximately ten times the population norm (Phillips, 1993). A Hong Kong study with a sample of 1007 community respondents found that nearly 50% of participants perceived people with mental illness as "quick-tempered" while almost 30% perceived them as "dangerous no matter what" (Tsang, Tam, Chan, & Cheung, 2003). Such direct stereotyping and discrimination appears to be related to the negative conceptions of serious mental illness. In a study using the Chinese version of the Camberwell Family Interview examining stigma experienced by people and families with schizophrenia, 60% of 1,491 family members of the person with the diagnosis endorsed that the patients experienced "moderate" to "severe" effects of stigma (Phillips, Pearson, Li, Xu, & Yang, 2002). Similarly, a study conducted in Hong Kong by Lee, Lee, Chiu, & Kleinman (2005) found that nearly 70% of 320 outpatients diagnosed with schizophrenia endorsed that disclosure of their diagnosis would obstruct their promotion at work. In fact, the majority of the respondents indicated that their work-related relationships deteriorated after disclosure while almost 45% of the outpatients

reported being laid off after their mental illness was revealed. The study also showed that almost 60% endorsed that they anticipated their partners leaving him/her if the mental illness diagnosis was discovered. As a result of the anticipated stigmatizing behaviors, more than 50% of the respondents have kept their mental illness as a secret.

Chinese families and mental illness stigma. One of the outcomes of perceived threat to the family social structure is the experience of expressed emotion (EE). High levels of criticism, hostility, and emotional overinvolvement characterize high EE. Research supports a strong correlation between increased number of hospitalizations with high EE families. Family interventions have been developed to assist with reducing high EE in communication. In the case of Chinese immigrant families, increased burden on a select number of family members may result in higher expectations for the client to reach unrealistic goals, which has been suggested as reasons for increased criticism and hostility within Chinese families (Phillips, Pearson, Li, Xu & Yang, 2002; Yang, Phillips, Licht & Hooley, 2004). Researchers have suggested that a way to counteract high EE is for the patient to attain more personal space from the family and to strengthen individual boundary to reduce stressful interactions (Phillips & Xiong, 1995). However, as described, seeking conventional psychotherapy or professional mental health assistance may simply be too stigmatizing and too incongruent with traditional beliefs around mental illness for these individuals. Thus, alternative interventions must address themselves to the way mental illness stigma is experienced via Chinese cultural processes.

In a case study by Lam, Chen & Leff (1995) of a Chinese family living abroad, they found that parents of a client diagnosed with serious mental illness reacted negatively to their adult child's desire to be independent and to move out of the home. The authors found that the family interpreted his desires as lack of filial piety, which carries a negative connotation in

Chinese culture. The authors noted that family members' resistance to a client's independence decreased when independence was presented as a process of establishing new and satisfying relationships. Allowing the client the opportunity to become a worthwhile member of the community through interpersonal connections and engaging in activities to demonstrate efficacy as citizens seemed to be better received by the Chinese family.

Lam, Chan, & Leff's (1995) case illustration highlights the fact that people diagnosed with serious mental illness often wish to be more active members of society. The son in the case study had a strong desire to expand his social circle, yet he was met with resistance -- resistance that presents a double-edged sword for Chinese immigrant families dealing with mental illness. On the one hand, the family member labeled with the diagnosis has not been trusted to make independent decisions due to reasons related to the issue of "face" as described earlier. The lack of opportunity for independent decision-making is supported by the belief that the views of the mentally ill cannot be trusted. Moreover, the possibility of an outsider's negative reaction to a person with a mental disorder would be considered to bring disrespect and humiliation. Such stigmatizing beliefs are picked up by the diagnosed person, who in turn internalizes the beliefs that people labeled with a mental illness do not deserve to practice independent thinking. On the other hand, if the diagnosed individuals do stand up for their beliefs, they are viewed as rebellious for disobeying a family's order or expectation since they are regarded as children. The catch-22 situation surrounds the individual with ambiguity and self-doubt, with the result that they may become reluctant, withdrawn, and even fear one-on-one interaction with people. Such was the situation for the son in the case study, where the mental illness stigma ultimately obstructed his desire to participate in volunteer work and classwork to enrich his life. The case study raises the question: how can mental health professionals appropriately address Chinese

adults with serious mental illnesses given the complex cultural factors that need to be taken into consideration?

Community-Based Mental Health Treatment and PAR in Chinese Communities.

In light of the previous discussion of Chinese culture and mental illness in the U.S., this section will consider how Chinese ethnic minorities with serious mental illness and their communities could benefit from an emancipatory and social justice approach such as PAR. Specifically, the section will consider conventional versus community-based approaches that have been applied to the population, as well as studies that have emerged from a participatory action research paradigm.

Chinese clients and mental health treatment. As the research regarding conventional treatment was profiled previously, only the prevailing conclusion will be restated here: the mismatch between Chinese cultural values and Western conceptions of mental health may help explain findings that traditional therapist-led, 45-minute psychotherapy favored in Western countries are not widely used by Chinese Americans (Wang & Kim, 2010). In fact, research examining mental health service utilization among Asian Americans has consistently shown a lower use of mental health services regardless of geographic location, age, gender, education, or Asian subgroup. Researchers have noted, however, the potential usefulness of community-based support services, such as mutual support groups, to serve as alternative interventions to address the stigma and threatened moral standing faced by Chinese individuals diagnosed with serious mental illness. Such interventions may also tackle the isolation that often accompanies the shame and social distancing resulting from the disorder.

In a study by Chien and Chan (2004), mutual peer support groups were compared with standard care and psychoeducation in the treatment of service users from psychiatric outpatient

clinics. The clients from the standard care group received monthly medical check-ups, individual consultation, welfare services, and psychological counseling on an as-needed basis. The clients from the psychoeducation group received education on the biological basis of schizophrenia, treatment, illness management, and coping skills. The mutual support group was a peer-led group that met for 12 groups sessions every two weeks over the span of six months. The mutual support group was designed to provide information, emotional support, and coping skills. Multivariate analyses of variance showed that clients who received the mutual support group had greater improvements in functioning and number of re-hospitalization, as well as the continuous utilization of mental health services compared with the other two groups. The opportunity to share feelings and experiences without fear of stigma, as well as garner emotional support and empathy, are well-established positive effects of mutual support groups in the U.S (Nelson, Ochocka, Janzen & Trainor, 2006). Mutual support groups also offer the unique opportunity for participants to re-examine their life from a different perspective and learn from other participants through the exchange of experiences and ideas. Many Chinese people believe that open discussion of feelings should not be encouraged for fear of disrupting social harmony and endangering the health (Meredith, Abbott, Tsai, & Ming, 1994). The study provided evidence that mutual support groups, or self-help groups run by and for the people, can be an effective alternative treatment for Chinese people with serious mental illness. This mode of interaction has the ability to help participants minimize their fear of being ostracized and of experiencing discrimination from others who might be insensitive to their illness; it also provides a platform by which individuals undergoing similar situations can share knowledge and experiences to improve recovery.

Studies that explore quality of life issues from the perspective of individuals living with mental illnesses have been rare but critical in assisting professionals with understanding the mental health issues experienced by the people labeled with the diagnoses (Corring, 2002). Quality of life has been defined as "an overall general well-being with the extent of personal development and purposeful activity, all weighted by a personal set of values" (Felce & Perry, 1996, p.60) and "the degree to which the person enjoys the important possibilities of his or her life (Renwick & Brown, 1996, p. 80). With regard to Chinese clients, Chan and Yu (2004) examined the perceptions of the Quality of Life (QoL) of 172 respondents recruited from a psychiatric outpatient department in Hong Kong. The authors combined a structured face-to-face interview on the Brief Psychiatric Rating Scale with the Hong Kong Chinese World Health Organization Quality of Life Scale-Brief Version. In their study, it was found that people diagnosed with severe mental illness had significantly less satisfaction with the QoL than from the general population in Hong Kong. The respondents reported a heightened level of stigma and discrimination not only for their mental illness but for the lack of life opportunities, such as employment and social engagements, resulting in their living a very disconnected and monotonous life in the community. The authors concluded that services for people with serious mental illness must not only focus on symptom reduction but also on promoting opportunities for clients to integrate into the community as active members. They further suggested that self-help groups or groups related to conscious-raising be incorporated in treatment to enhance coping and problem-solving skills (Chan & Yu, 2004). Though the literature on QoL is scarce, especially among the Chinese population, other QoL studies on service users of the mental health system support the need for peer support (Renwick & Brown, 1996), self-help programs where people could help others as well as finding a supportive, caring environment for oneself (Chamberlain,

Rogers & Ellison, 1996), and have a support system of professionals who would listen and who could be trusted (Corrigan, Roe & Tsang, 2011) as elements essential to successful recovery.

The literature on serious mental illness often comprises the need for psychoactive medication although social support and the ability to engage in social function are often strongly implied in prognoses as well. Ran, Xiang, Huang and Shan (2001) conducted a comparison study between patients with schizophrenia who had never received psychiatric treatment versus those who had, and the factors that affected prognosis among those who had never received treatment included inadequate social support. The authors concluded that psychosocial intervention and medication should occur during the early stages of the illness. Furthermore, the individuals who carried on active, productive lifestyles, such as in taking care of the household, children and the farm, seemed to have prevented deterioration from the mental illness. The study indicated that occupational functioning for patients with schizophrenia did not correlate with symptom severity. Among participants, 77.6% of the patients who had never been treated could still participate in part-time or full-time work. The authors determined that patients who had marked psychotic symptoms could still engage in housework and farm work, undermining assumptions that their activities should be restricted. Furthermore, the results remind us that treatment should not singularly rely on the medical model. Although a comprehensive treatment approach is supported, patients diagnosed with serious mental illness who are not on medication can still have the capacity to function independently, engage in crucial functions, and participate in active and meaningful lifestyles.

PAR and Chinese participants. Despite its recognizable impact, PAR is still in its infancy stage within the mental health literature, especially with minority populations, and especially for Asians and Chinese (Stacciarini, Shattell, Coady & Wiens, 2010). A review of

PAR/CBPR by Stacciarini, Shattell, Coady & Wiens (2010) that culled results from several electronic databases revealed that less than 20 studies had been conducted using PAR with minority populations in the U.S. The authors found that approximately only 1/5 of the studies used a diverse sample to examine the utilization of PAR to address mental health among minority populations (Stacciarini et al., 2010). This finding is striking in light of recent U.S. Census Bureau (2010) results that show that the percentage growth of Asians alone makes up more than any other major race group. Furthermore, Chinese-Americans comprise the largest Asian group, yet none of the studies focused on the specific development and treatment needs of the U.S. Chinese population with serious mental illness. In fact, the literature is conspicuously absent from PAR studies of Chinese participants with clinical mental health concerns. A literature search on Google Scholar presents only a few studies that broadly corresponded to the search criteria for participatory action research and Chinese and psychological health. Of the three studies that broadly looked at Chinese participants' emotional well-being as one of its outcomes, only one project was conducted solely by Chinese people (Wang, Burris & Ping, 1993); another was conducted with Chinese community leaders and stakeholders on a host of health concerns (Dong et al., 2013); and one study only had one Chinese participant of a group of women of color (Cahill, 2007).

In the first of these studies, Wang et al., (1993) grounded a PAR project in empowerment education, feminist theory, and documentary photography. Their project was conducted with a group of Chinese women in Yunnan, China, to promote the specific concerns of a group whose voice was not heard in the policy arena. Together, the country women engaged in photo novella creation to portray rural life as experts on their own lives. The rural women's "visual voice" told rich stories about "the nitty-gritty in their daily lives" and aroused interest and curiosity within

the larger population (Wang et al., 1993, pp. 1393-1394). They were able to convey women's hardships as well as inform policymakers from provincial and county level offices and national and local media reporters about public health, family education, poverty alleviation, which were areas identified by the women as crucial influences in their lives. Through the successful photo exhibition supported by the Ford Foundation Women's Reproductive Health and Development Program, links were formalized between policymakers and the village women, and leaders from the bureaus of Public Health, Family Planning, Education and Poverty Alleviation. Researchers from Kunming Medical University, Beijing Medical University, and provincial, county and township officials came together to engage in policy dialogue regarding the reproductive health and rural development policies that profoundly affected the village women's lives. The women were able to influence policy as exemplified by three outcomes: the creation of a daycare facility, midwifery services, and women's educational programming. The daycare was set up because many women were worried about their children playing near water in an unsupervised manner while the mothers worked. Furthermore, the women always had their babies with them, squirming in blankets amid fields of tobacco and corn. The infants lay exposed to rain and sun while their mothers engaged in hard labor. Women's education was developed because they often had no choice but to give up working to rear children. This study demonstrated the possibility for village women, whose voices are never heard, to influence policy through their power of visual image. These actions demonstrate the gains of participating in research that is collaborative, collective, and community-based to honestly and adequately address women's voices via photo novella. The action-orientation of PAR has shown to be useful in effecting change in the status quo and redistributing uneven resources in communities that are typically left out of the process of policy decision-making.

Dong et al. (2013) partnered with a community service agency in the Midwest serving the needs of Chinese populations. The academic researchers recruited Chinese community leaders and stakeholders to help strategize participatory research in ways that were grounded in local Chinese cultural context. Through a series of community advisory board meetings comprised of Chinese community leaders, the community-academic co-researchers were able to identify health needs, workshop topics, and presentation materials to ensure that information could reach older Chinese community members via culturally sensitive and appropriate methods. The workshop topics focused on breast cancer, depression in older adults, elder abuse, nutrition and aging, stroke prevention, screening, diagnosis, and treatment. Pre and post questionnaire scores indicated that Chinese older adults held limited knowledge on the health topics. With the exception of Chinese older adults' knowledge on stroke, there was significant improvement on the understanding of the remaining five health topics following the workshops. The collaboration revealed key factors to attaining high workshop performance with the population, including matching participants' dialect preference, having some understanding of how stigma manifests and is attached to certain conditions such as cancer and depression, and conducting workshops at community centers where participants were familiar with the settings and had easy access to the workshops.

Potential benefits of engaging in PAR with ethnic Chinese immigrants with mental health concerns. Many Chinese families' natural social support systems are limited due to their immigrant status. At the same time, research has documented that Asian Americans, including Chinese Americans, underutilize mental health services. Some researchers attribute to the low utilization as due to the Chinese cultural belief that seeking help symbolizes a family's inability to take care of its own. PAR has the potential to function as a community-based service that is

not clinical or pathologized in nature, and that also teaches participants practical skills and knowledge. It offers participants an opportunity to receive supportive services without necessarily requiring insurance coverage or worrying about language barriers between the therapist and client, in that it could involve Chinese people coming together to support each other. Participants that join together in a PAR group have the increased cultural compatibility that is often encouraged between therapists and clients (Kung, 2001).

Moreover, seeking professional mental health treatment can be a form of losing face. To preserve face, Kung suggested the use of a psychosocial model to modulate a family's sense of guilt over the hereditary factor (Kung, 2001). Kung (2001) suggests that a psychosocial perspective is something to which immigrant families can more easily relate as there are a number of psychosocial stressors as members of the U.S. society, including racism. Furthermore, a psychosocial perspective is in line with the cultural belief that inharmonious and states of imbalance can cause an imbalance in the body. PAR can serve as a stepping-stone for the individual to begin grappling with internal and external imbalances through mutual, culturally sensitive interactions. Research suggests that Chinese may prefer a more goal-directed structure in their activities, particularly with clear and realistic goal objectives that are outlined rather than in open-ended forum. By engaging in the cycling process of interacting with others, issues can become more specific. Sensitive issues can be discussed honestly and with respect and passion. Given the action-oriented nature of PAR, Chinese people can exercise their tendency to show mutual concern and support by seeking to meet each others' actual needs since they have been found to value practical assistance and problems solving skills rather than merely talking about feelings (Chien & Thompson, 2008). Kung (2001) suggested that family members foster more autonomy in the family member identified with mental illness. PAR can facilitate this process as

it allows clients to discuss ways to increase their problem-solving skills. Learning from each other's experiential knowledge can strengthen participants' own problem-solving skills that could lead to less dependence on family members, and the effects that can result from over-involvement and decreased sense of autonomy in both parties, such as resentment, criticism, excessive sense of shame and embarrassment.

Part of recovery for Chinese individuals with mental illnesses is the development of a healthy sense of honor for one's unique self and the achievement of an optimal level of autonomy within a collectivistic community embedded within a larger individualistic society. Engaging in a PAR group can assist with the process of attaining a satisfying medium between independence and healthy co-dependence. A PAR approach provides an opportunity for patients to form bonds and to support, encourage, and interact in more intimate ways. It allows participants to discuss issues at levels at which they are comfortable and to explore cultural and family expectations that are particularly relevant to them while integrating professional feedback with the help of reflecting openly as a group (Kung, 2001). PAR provides a space to explore in non-pathological manner explanations that encourage hope and growth, which aligns with the exploration of environmental stresses, combined with a person's vulnerabilities, that may be more acceptable and hopeful to a client and their families.

In Chinese, the diagnosis of schizophrenia is translated as the splitting of the spirit, which can be extremely frightening, repulsive, and disheartening, and which in itself can cause an individual to distance himself/herself from others. Gaining established social support is crucial to the recovery process. As a means of limiting isolation, PAR creates an opportunity for individuals to process feelings and the impact of their experience with others undergoing similar circumstances, which could ease their sense of isolation and experience supportive care. The

space allows PAR participants to take on active roles in exploring the meaning of their diagnoses to themselves, and to explain and dispel misconception based on personal experiences. Importantly, PAR also addresses the environmental and societal contexts in which issues derive. It provides a space to explore mental illness in a non-pathological manner, which can encourage hope and growth. The conversation can include an exploration of environmental stresses, combined with a person's vulnerabilities, and together provide a more complete picture, one that induces more hope and acceptance of a complex individual.

Purpose of the Study

The primary aim for this study was to explore the utilization of a PAR approach as part of the recovery process for Chinese people living with schizophrenia in the U.S. The study also represented an intention to share power and support the voices of this highly disenfranchised and marginalized group within a social justice framework, and to lend access and visibility within the academic and research literature. The study comprised consideration of relevant Chinese cultural beliefs, values, and attitudes regarding serious mental illness as it addresses specific mental health care needs and issues confronted by Chinese immigrants and their community. Using a PAR approach, this study examined numerous potential research topics in concert with Chinese community co-researchers diagnosed with a serious mental illness. The PAR process, comprised of culturally-sensitive approaches, followed throughout the implementation of the research questions. The co-researchers were involved in every step of decision-making from the method, analysis, interpretation and action phases. In so doing, the study attempted to facilitate a conceptual connection between concerns experienced by the co-researchers with actions that resolved the problems. Thus, community members engaged in the co-creation of knowledge and resolutions for issues that were of pressing concerns to them, and addressing unjust systems and

practices that contributed to the problems, and achieving more meaningful and lasting personal, collective, and systemic transformations.

Chapter III

Method

Chinese immigrants with serious mental illness diagnoses carry unique cultural values, beliefs, practices, and intersectional identities with collective and subjective experiences of discrimination, marginalization, and disenfranchisement. These experiences are often neglected or misconstrued by outsiders of this specific community. Contrary to defining the issues and lived experiences of Chinese immigrants living with serious mental illness through traditional Western methods of investigation, PAR seeks to create knowledge in the context of race, gender, culture, and other intersecting identities, as well as the power hierarchies that community members are affected by.

This emancipatory approach aims to empower oppressed people to challenge the power and privilege from traditional academic knowledge-making practices and their political domination over communities (Reason & Bradbury, 2006; Schneider, 2012). Credence is therefore afforded to: the subjective lived experience and cultural values and norms of Chinese immigrants with serious mental illness who are survivors of the "chronic terror" of serious mental illness (Karon, 2007), the social stigma that prevails over popular culture, and the oppressive and patronizing attitudes of long-term medication use and hospitalizations that transfer onto community care (Davidson et al.,1997).

This dissertation study attempts to position PAR as an intervention with community members who have been pushed to the margins as a result of complex intersecting identities. The Chinese community co-researchers are recognized as full agentic participants in cooperative inquiry with university co-researchers whereby a two-way flow of information takes place: community co-researchers provide their expertise by lived experience of local community and

mental health issues and university co-researchers offering tools and information to enable community members to implement research, take action, and act as change agents regarding practical issues that are affecting their community (Minkler & Wallerstein, 2001; Schneider, 2012).

A PAR intervention model demands that the community co-researchers' voices are amplified and involved in every aspect of the research. As Chinese co-researchers on a PAR team, participants are engaged in critical consciousness raising (Freire, 1970) regarding the "everyday banality and seeming inevitability of injustice" (Fine & Torre, 2006, p. 255).

PAR studies can potentially include data collection by any method that a co-research team chooses during the study. While there is little formal scholarship on PAR methods, feminist and multicultural scholars with community co-researchers of past PAR projects have offered various examples of forms of data collection and research techniques that are grounded in biographic, cultural, historical, and political contexts (Wang, 1999; Cassano & Dunlop, 2005; McIntyre, 2008).

A PAR team is obligated to pay constant attention to the insider/outsider positionalities occupied by community and university co-researchers as the research topic is narrowed. This process requires that the team deliberate on questions such as, whose research questions are these, and "[w]hat are the goals of the research in terms of actions derived from it or as part of the process?" (Herr & Anderson, 2010, p. 82). Consideration of these questions provides opportunities for reflection by the team as well as to help ensure that the methodology will continue to develop and shift in keeping with the community-based interests that the project represents. It also allows the team to maintain awareness of "power relationships with both the

dissertation committee and the [co]researchers, and the larger issue of who, exactly, was going to benefit from this project" (McIntyre, p. 23, 1997a).

In conventional research, there is a relatively clear, agreed-upon distinction between methods and results of the project, and traditional chapter titles reflect this. In PAR, these distinctions are blurred: the development of the structures and methods that describe the project is part of the project itself. As a result, this dissertation will proceed with an organization that generally corresponds to conventional styles while permitting the most effective record possible of the actual project. This method chapter will describe the logistical and descriptive details regarding the launch of the project, including the agency and project participants. The following results chapter will present the process and activities that transpired as part of the project process itself. A list of action steps taken to establish the PAR collaboration and diagrams of action steps carried out with PAR team members/ co-researchers during and outside of PAR meetings will also be presented.

The Setting

The project took place at a full-service mental health community agency in the Two Bridges/ Chinatown area of the Lower East Side of Manhattan New York. The area has a total population of 168,298 people, and it is the largest and oldest enclave of Chinese people in the Western Hemisphere (NYC Health, 2015). More than 59 percent of NYC's Chinatown residents are foreign-born with 89 percent born in Asia and hail from the ethnic groups of Guangdong, Toisan, Fujian Providences and Hong Kong (Asian American Federation of New York, 2004). Historically, the Lower East Side, including the Two Bridges/ Chinatown area, was primarily occupied by European immigrants across the late 19th and early 20th century (Takaki, 1998). This highly populated, poor neighborhood was one of the first in the city to be racially-integrated.

Chinese were categorized as "Others" in the census of Lower Manhattan, distinct from Whites, Blacks, and Puerto Ricans because of their relatively small population (Li, 2015). At that time, the city was comprised of crowded tenements that contained limited infrastructure, government assistance, and high rates of disease and gang violence (Kwong, 1979). Humanitarian efforts, such as the Henry Street Settlement on Hamilton Street offered relief, social services, healthcare, and educational programs to the poor families that resided the community (Mendelsohn, 2009).

Waves of immigrants and racial groups settled the area in the early to mid-20th century. By 1965, the demographics of the neighborhood shifted to becoming primarily Chinese due to changes in federal immigration policies. The removal of the Exclusion Act in 1943, increase in immigration quota, along with the influx of foreign money led to rapid expansion of the area (Wang, 1999). Crowded tenements and densely concentrated buildings in New York City transformed into garment factories and office buildings. Numerous Chinese immigrants took up low-status service jobs in restaurants and hand laundries. Tourism of the area also developed out of economic need and limited opportunities made for Chinese residents (Li, 2015). With the influx of overseas capital on commercial activities, NYC Chinatown gradually became an epicenter of historical, cultural, social, business, and immigrant activity (Li, 2005).

Conversely, the Lower East Side neighborhood has also witnessed widespread gentrification. Long-term residents of Chinatown and along South Sea Seaport historically relied on small, family and individually owned shops and restaurants where they could speak their native languages, reinforce social bonds, and feel comfortable within their geographical community. However, the neighborhood is increasingly gentrified by more white, wealthy and college-educated residents, leading long-time residents to feel "excluded and unwelcome" (New York City Bureau of Policy and Research, 2017). According to the 2017 New York City Bureau

of Policy and Research report, Asian, black, and Latino populations of the neighborhood have dropped, while the white population increased by approximately 19 percent. Residential gentrification has also contributed to class polarization in the area, causing many poor working class families from the neighborhood to be pushed out to areas such as Sunset Park, Bensonhurst, and Flushing (New York City Government, 2011).

In recent years, Chinatown experienced positive median income growth of 27.5% from $23,253 to $29,658, and family income rose 31% from $24,728 to $32,399, although many households still live below the poverty line with high rates of child and senior-citizen poverty (New York City Government, 2011). Chinese seniors have a poverty rate of 30.5 percent compared to 18.2 percent for all elderly New Yorkers. The poverty rate for Chinese working-age adults (age 18-64) grew from 15.3 percent in 2008 to 18.6 percent in 2011, compared with 15.5 percent to 17.5 percent, respectively, for overall adults (Asian American Federation of New York, 2013). The median income in Two Bridges remains approximately 60% below the NYC median household income.

Chinese in New York City have the highest rate of limited English proficiency. 63 percent of Chinese adults (age 18-64) and 88 percent of Chinese seniors have English limitations, compared with 24 percent and 33 percent respectively for all New Yorkers (Asian American Federation of New York, 2013). Chinese in New York City have less schooling than citywide population. Among Chinese adult population, the percent of individuals without a school diploma increased from 36 percent in 2008 to 38 percent in 2011, while the citywide rate was at 21 percent. 30 percent of Chinese had a bachelor's degree or higher while the city overall was 34 percent (Asian American Federation of New York, 2013).

The Agency

Services historically provided at the Chinese Mental Health Center (CMHC). As previously noted, CMHC emerged via a humanitarian effort to meet the evolving needs of the growing community. This effort was launched by humanitarians such as Lillian D. Wald, an American nurse who advocated for nursing in school and rights of women and minorities (Henry Street Settlement, n.d.). Through the years, the facility has developed numerous programs to assist the diverse needs of the community across the lifespan. Vanguard programs at CMHC ranged from the first Chinese senior center; pre-school day care, adolescent service care, and family care for Chinese immigrants; The Asian American Mental Health Demonstration Project that specialized in bilingual, bicultural services for the city's Chinese, Japanese, Korea, and Southeast Asian communities; the Chinatown Alcoholism Project; the Federation of Protestant Welfare Agencies to create beds for homeless people; the Ryan White Teen Outreach Project to support HIV/AIDS at-risk and affected youth and their families (closed in 1998); the CMHC Knickerbocker Village Senior Center; and The Two Bridges Tower at 253 South Street, a residential building for mixed income and homeless families ("History," n.d.).

Current services provided at CMHC. CMHC currently operates six major branches which include a senior center, behavioral health services, youth development programs, immigrant services, early childhood, and family child care. The behavioral outpatient health and clinic offers diagnostic assessment, psychiatric and psychological evaluation, individual and group counseling and psychopharmacologic therapy, the first Chinese-speaking Personalized Recovery Oriented Services program for Chinese adults with psychiatric disabilities (PROSpect Place), the Asian American Recovery Services program for substance use and gambling issues; and a professional consultation and training for graduate students in social work and psychology.

PROSpect Place (PROS). The PAR collaboration took place within PROSpect Place, which provides comprehensive care to support PROS participants' recovery and wellness through identified goals and services decided with their PROS counselors. At the time of PAR implementation, there were approximately 60 participants enrolled at PROS. Most services are implemented in group formats (similar to a school curriculum) plus individual contact with staff. In addition to addressing client-centered treatment goals and the respective means and objectives to achieving those goals, participants can also obtain help on issues regarding living, working, social and educational situations.

PROS eligibility criteria delineate that its participants must be of 18 years of age or older, designated with a mental illness diagnosis, and experiencing significant functional deficit due to the severity and duration of the mental illness. As described on the service information page of the CMHC website, PROSpect Place also facilitates learning and recovery in the areas of referral to benefits application services, community events, computer classes, and English classes (Behavioral Health Services – PROSpect Place, n.d.).

PROS programs must meet standards issued by The Office of Mental Health to qualify for reimbursement under the medical assistance program. PROS providers offer the following 17 types of services (a) assessment; (b) basic living skills training; (c) benefits and financial management; (d) clinical counseling and therapy; (e) cognitive remediation; (f) community living exploration; (g) crisis intervention; (h) engagement; (i) family psychoeducation; (j) health assessment; (k) individualized recovery planning; (l) information and education regarding self-help; (m) integrated treatment for co-occurring mental health and substance abuse disorders; (n) intensive rehabilitation goal acquisition; (o) intensive relapse prevention; (p) medication

management; (q) ongoing rehabilitation and support; (r) pre-admission screening; (s) psychiatric sssessment; (t) structured skill development and support; (u)
symptom monitoring; (v) wellness self-management (Personalized Recovery Oriented Services, n.d.).

Staffing. At the time of this PAR project's implementation, PROSpect Place employed three full-time counselors and shared two patient coordinators, one part-time psychiatrist, and one part-time nurse practitioner with the outpatient services of CMHC. Full-time counselors run an average of 8-12 groups per week, all of which are psychoeducational and skill-driven. They also ensure participants' attendance of their appropriate groups and that mealtime run smoothly. The counselors also meet with individual participants for clinical services or counseling, and to facilitate case management, care coordination, and communication with families. The participants meet with their treating psychiatrist or psychiatric nurse practitioner monthly for clinical and pharmacological treatment. The director of PROS, psychiatrist, nurse practitioner, and counselors hold weekly team meetings and "semester" meetings every 16 weeks to modify group schedules. The participants do not attend these meetings. PROSpect Place does, however, hold community meetings with all staff and participants to speak about recent events and program-related issues as needed. The psychology interns run approximately 1-2 groups and provide individual counseling with 1-2 participants within PROSpect Place. Additionally, PROSpect Place participants previously worked with a longstanding vocational specialist at CMHC who helped bridge vocational opportunities in the community and assisted the participants with seeking volunteer and vocational experiences. Sadly, the vocational specialist resigned from CMHC approximately one year following PAR implementation.

Membership of the Team

In all descriptions of agency staff and PAR team members, pseudonyms are used in place of real names.

University and agency co-researchers. Despite its inherently collaborative nature, PAR projects are most effectively and responsibly undertaken by academic investigators who have had training and experience to prepare them for a community partnership. In my case, I entered the agency in the third year of my doctoral study in counseling psychology at Columbia University and began my role at CMHC as a psychology extern in June 2012.

Primary Investigator. I am a Chinese female immigrant who was raised in Hong Kong, currently a Special Administrative Region of the People's Republic of China, and North America. As such, I am sensitive to sociocultural influences on the psychological development of individuals and families of culturally diverse reference groups. My educational background includes a B.A. in psychology from Canada, furthered by a Master's in family therapy and the systems perspective from the University of Hong Kong, particularly in the area of collaboration with community agencies to develop culturally-appropriate mental health interventions for families that are challenged by issues such as poverty and domestic violence, and consultative work with government agencies, including the Social Welfare Department and the Hospital Authority of Hong Kong. My interests in community-based mental health services and ethnic Chinese mental health issues have been further fostered by the multicultural counseling courses and training at Teachers College, my coursework on community consultation and socially-just community-based practice, and training and research experience in the area of serious mental illness at inpatient and outpatient clinical settings. I also have previous PAR experience in that I have spent five years as a member of a research team in my doctoral program where numerous PAR projects are discussed and supervised on a weekly basis by the group. In addition, I

completed a two-semester course on school-based youth participatory action research (YPAR), during which I co-facilitated a year-long YPAR project at a middle school in the Bronx, as well as a year-long PAR-based intervention at Covenant House, a community-based shelter in Manhattan.

Positionality. With regard to my positionality within the proposed research project, I am both inside and outside: I am an insider as a Chinese immigrant woman who, as a child, was raised in Hong Kong before my parents, three sisters, and I immigrated to Canada. We were one of many Hong Kong families that left the city in masses for fear of political and economic instability following the handover of Hong Kong in 1997 from the United Kingdom to the People's Republic of China. Mobility and access to resources were concepts that fueled the engines of my family; one that has survived generations of chaos and upheaval. With a Mainland Chinese father who survived Mao's Cultural Revolution and fled to the then-British colony of Hong Kong, and a mother who is a daughter of National militant parents who fled Communist China and found political refuge in Taiwan, fleeing the homeland to ensure the children's safety and access had become my family's legacy of immigration and survival. Stemming from that, my family and I had to rely on a tight-knit Chinese community to navigate the disconnections from cultural barriers of a new country and to strive for healthy identity integration. My insider status also extends to my educational background as the first generation to attend college. I further identify as non-religious, which could be argued as historically mainstream due to strict religious policies and past bans on religion enforced by the Chinese Community Party, although numerous religious groups have revived through recent years.

My outsider status begins with my identity as a heterosexual, married female. My married status is a privilege that individuals carrying serious mental illness diagnoses are

typically denied due to severe stigma, discrimination, and social distancing occurring against this population. My family could be described as middle-upper class as my father was a successful entrepreneur and our privileged social class status has provided my family and me with far-reaching social and financial capital. My outsider status also extends from my educational background as a doctoral candidate of a prestigious institution. Anderson and Jones's (2000) continuum on positionality would term my position as the "outsider in collaboration with insiders" since I am a university-based researcher who entered an organization or community to collaborate in a project. I have access to knowledge that is traditionally closed off from community wisdom and practices, and it has been posited by action researchers that this collaboration has the potential to contribute knowledge toward improved professional practice, practice-related critique, as well as organizational development and transformation (Anderson & Herr, 1999; Bradbury & Reason, 2001; Heron, 1996).

Agency co-facilitators. Congruent with group facilitation techniques, the PAR team at CMHC operated with two co-facilitators throughout its implementation. The initial four months of PAR was enriched by the presence of Jiang (a master's level practicum student in psychology from New York University, who showed a keen interest in multicultural mental health interventions. Jiang was a passionate supporter of PAR. With his prior experience as a group facilitator for other mental health groups at CMHC PROS and his strong rapport with the participants at PROS, Jiang proved to be an effective and enthusiastic co-facilitator who was open to incorporating unconventional methods of running group activities. His departure was greatly regretted by the agency and the PROS participants. By May 2013, the PAR team heartily welcomed the inclusion of a longtime PROS counselor, Tao who was also a passionate learner of PAR to join as the team's co-facilitator. Together with the PAR co-researchers, she was eager to

utilize social justice approaches to facilitate our co-researchers' personal and collective journey towards recovery. Tao stayed with CMHC PROS until February 2015.

Following Tao's departure, Chen, who was a graduate of the Ed.M. program in Counseling Psychology at Teachers College and a full-time staff member at CMHC, joined the team as a new facilitator. Chen and I co-facilitated the PAR team until my departure from CMHC in May 2015 to fulfill a year-long, full-time predoctoral internship. Our PAR co-researchers advocated for the group's continuation despite my termination at the agency and Chen remained as the facilitator of the PAR team at CMHC.

Supervisory support. The PAR program received ongoing supervision and support through two main channels: 1) weekly discussions with a counseling psychology faculty member/supervisor and a research team that consists of master's and doctoral-level students who have/ are currently conducting PAR projects in the community and who are well-versed in the literature and pragmatics of PAR with community stakeholders; and 2) supervision at CMHC from the director of the PROS program and the director of outpatient psychological services.

Supervisory support through the research team at Teachers College. Throughout the two-and-a-half-year duration of the PAR project at CMHC, I attended weekly meetings that were held at Teachers College (TC), Columbia University, with approximately 8-15 master's and doctoral-level students, two doctoral-level research team coordinators, and a faculty member. Every week, all current PAR co-facilitators (myself included) offered updates regarding their respective PAR teams' progress and areas that they would like to address. The information that I presented consisted of my reflections of the CMHC PAR team's development and gaining feedback on the choice points of my intervention and facilitation. I also served as a liaison and

presented messages, questions, and concerns from the PAR team at CMHC as requested by my PAR co-researchers to the research team at TC.

Supervisory support through CMHC. The supervision and professional support from the director of the PROS program and with the director of psychological services at CMHC occurred on a need-to-know basis according to the co-researchers' decisions and according to administrative procedures to ensure that operating standards were met for the PAR team to run smoothly. There were two occasions when the director of CMHC outpatient psychological services requested to sit in on the PAR meetings to demonstrate support for the PAR research as well as to offer PAR co-researchers the opportunity to communicate their viewpoints directly with the director. The director of PROS also attended several PAR team meetings. The meetings with the PROS director were held under the request of the PAR co-researchers to discuss plans and issues of concern.

Peer supervision. Peer supervision between the co-facilitators occurred on a weekly basis. Following each PAR meeting, my co-facilitator and I would process our reactions and brainstorm ideas regarding the observations made, the issues discussed, and potential resources to help facilitate the team's plans to fruition. Peer consultation continued following my departure from the PAR team and during Chen's continued facilitation. Weekly supervision took place for the first six months followed by bi-weekly phone meetings and check-ins as needed.

Other support staff. During the first year of the PAR implementation, three counselors were employed on full-time status within the PROS program at CMHC, one of which was Tao. The other two counselors also had direct and indirect involvement in the PAR team by way of referring their PROS participants to the team, engaging in regular check-ins with their respective PROS participants who were PAR co-researchers, and ensuring that those co-researchers found

their participation in PAR to be helpful and congruent with their identified treatment goals and objectives at PROS. The counselors also played direct roles in the PAR projects, such as helping with survey dissemination and collection, coordinating gatherings and community excursions to meet the co-researchers' requests, and other forms of facilitation as directed by the PAR co-researchers.

Community co-researchers. When the group first commenced on January 23, 2013, the PAR team at CMHC consisted of six participants (four women and two men). In accordance with our co-researchers' wishes, pseudonyms will be used in the depiction of their experiences throughout the dissertation, and descriptive details will be kept broad and non-specific. This decision for anonymity was made based on the co-researchers' concern regarding their individual and family's confidentiality. Our co-researchers held a primary concern not to cause further wrongdoing to one's family when one has already achieved severe shame and guilt for the loss of identity and failure to live up to expectations as someone in recovery from serious mental health concerns.

The original six co-researchers were Jing-Jing (female), Grace (female), Patty, Amanda, Ah-Tung (male), and Ke-Ming (male). Grace, Patty, Amanda, and Ah-Tung have lived in the U.S. for an average of 15 years. Jing-Jing and Ke-Ming moved to the U.S. after 2011. Patty came from Hong Kong while the remaining co-researchers immigrated from the People's Republic of China. All co-researchers carried a serious mental illness diagnosis, including schizophrenia, schizoaffective disorder, and bipolar disorder with psychosis, and have received psychiatric treatment and mental health services for an average of nine years. All co-researchers were either recipient of Supplemental Security Income (SSI) and received Medicaid or Social Security Disability (SSD) recipients and received Medicare.

The composition of our co-researchers shifted during the initial three months of implementation. Ke-Ming stopped attending the PROS program in February 2013. Amanda attained full-time volunteer work and therefore stopped attending PAR in April 2013. Jing-Jing withdrew from PAR in September 2013 as she decreased her overall attendance at PROSpect Place. Grace, Patty, and Ah-Tung continued their PAR participation and initiated recruitment for more participants in September 2013. Because of their recruitment efforts, three more PROS participants joined the PAR team. They were Lai-Do (female), Bai-Hua (female), and Ming-Zuo (male). During September 2013, two other members, Ge-Li (female) and Andy signed on to PAR through discussions with their respective counselors. The five new members were all immigrants from China. Both Bai-Hua and Andy were new participants of PROSpect Place. In November 2013, Tina and David, who transferred from another PROS program in Queens, NY joined the PAR team. By November 2013, the PAR team consisted a total of 10 co-researchers and two co-facilitators. The co-researchers' ages ranged from 22 to 47 years.

Language Considerations. The PAR teams were conducted in Cantonese Chinese and Mandarin Chinese as nine out of our ten co-researchers understood both dialects. Patty mostly spoke and understood Cantonese Chinese. Except for Patty and Grace, all remaining co-researchers could speak Mandarin. Two co-researchers (Tina and David) spoke only Mandarin although they could comprehend Cantonese. I, along with the three co-facilitators (Jiang, Tao, and Chen), are fluent in Cantonese and Mandarin. The co-facilitators and I frequently provided verbal check-ins with the team members to ensure that all team members could follow and participate in the team discussions. All co-researchers who were comfortable with speaking both dialects participated in translating and interpreting the material discussed during the team meetings. All team members, except for myself, were comfortable with reading and writing

simplified Chinese. A few co-researchers were also able to read traditional Chinese. I am somewhat proficient at reading traditional and simplified Chinese but not in writing. As such, my co-facilitators and co-researchers were much more involved with assisting me and writing out the materials derived from the team discussions.

Form of Data Collection: Records and Artifacts. The team created various types of records throughout the collaboration to capture the processes and experiences gained from the projects. The team often made use of writing notes in Chinese or drawing diagrams and flow charts on large poster papers to illustrate the ideas, concerns, and critique on current events and literature reviews generated from the team discussions. Pictures of the works produced from the discussions were captured for photographic data and stored in a locked room at the agency. All versions of written and typed documents generated from the team meetings were digitally saved and password protected. All materials (photographic, written, and typed data) emerged from the PAR discussions were frequently referred to and analyzed during PAR meetings as they served the platform for the team's reflective discourse, action, and research.

Setting the Stage for PAR: Exploratory and Pre-project Work

Having helped run groups as a psychology extern at CMHC for approximately six months and ample opportunity to get to know the agency's participants and counselors, I suggested developing a PAR team that supports PROS' recovery-oriented with elements of advocacy and social impact that contrasted from the existing groups at PROS. PROS at CMHC offers a variety of interventions and treatment groups to facilitate the treatment goals and objectives decided by the participants with their counselors. Each PROS participant is assigned to one PROS counselor. Part of the objectives at PROS is to encourage equity, citizenship, and collaboration between staff and participants. The project that I proposed as an addition to PROS

came to fruition with the support of my supervisor at the agency who was also the Director of Outpatient Psychological Services of CMHC, the Director of PROSpect Place at CMHC, the Assistant Executive Director of CMHC, the Medical Director of CMHC, along with the faculty member at Teachers College, Columbia University.

Development of PAR guidelines and practices. To ensure the quality of the proposed PAR project and to gain a broad understanding of how the sessions could potentially engage the participants in a safe, respectful, inclusive, informative, and educational manner, I was requested to develop a 6-week outline of potential PAR activities for presentation to the Director of Outpatient Psychological Services and the Director of PROSpect Place. In the outline, I detailed specific activities that could be utilized to establish relationships and stimulate conversations regarding the participants' roles as valued change agents to promote positive changes that they saw necessary. I was also requested to conduct an *in vivo* demonstration of a PAR session using the tools and topics that I had outlined in the proposal with my supervisor and the PROS program director. I received invaluable feedback on how to adjust my use of language and activities to better meet the functional level of the participants. They encouraged the incorporation of various untraditional means of therapeutic and creative endeavors, such as art, photography, music, internet, and field trips to complement the more traditional class-based format of PROS programs. The PAR curriculum was approved after revisions were made to the curriculum.

Based on these provisions, the clinical administration at CMHC approved the future implementation of PAR for PROS participants and a memo of understanding (MOU) was signed. The MOU was submitted with the IRB application to that effect after the initial 5-month phase of pre-IRB collaboration (May 2013) for the participants to be experientially informed of the PAR

process. The English- and Chinese-version of the consent forms are contained in Appendices A, B, C, D, E, F. A second MOU along with a renewed IRB for continued PAR collaboration at CMHC was submitted in May 2014 after the PAR co-researchers advocated for another year of collaboration. The renewed English-version of the consent forms are contained in Appendices G, H, I and Chinese-version of the consent forms are contained in Appendices J, K, L.

Creating fair, informed, and transparent consent. The first stage of this partnership entailed CMHC management taking on the decision to be one of the first known community mental health clinic serving Chinese clients to implement a recovery model that actualized a participatory action research framework within the parameters of New York State Office of Mental Health Personalized Recovery-Oriented Services.

The opportunity was presented to PROS participants who have expressed interest in: less structured, more open-ended, and process and action-oriented research groups in January 2013. A democratic and socially just approach such as PAR required an opportunity for CMHC PROS participants to partake in the experiential involvement of the research collaboration before voluntarily signing onto the collaboration—a process that goes above and beyond conventional research recruitment in order to ensure fairness, transparency, and ownership of the PAR team. As such, the participants who were interested in learning about the PAR modality were invited to join the pre-project IRB team meetings in late January 2013. The initial 5 months of implementing PAR at CMHC was spent on creating a safe, exploratory, and interactive approach to understanding the co-researchers' experiences, concerns, and areas that the co-researchers felt compelled to understand and enact change before making the decision to stay on the team as co-researchers of my dissertation study following the first five months of pre-project meetings.

Protection of participants. In PAR, the team of co-researchers – both academic and community members – choose the study topic and design together. Typical IRB procedures are often not sufficient for the protection of community co-researchers' rights to consent to this process. The most obvious problem is that co-researchers are *not* research subjects – yet their roles as less socially-powerful participants in the PAR process must be addressed. Concerning the vulnerable population represented in this study, these protections needed to be extended even to the process of considering my invitation to participate. For that reason, I submitted a pre-project IRB concerning this process, with the explicit provision that no research question had been established and no data was being gathered at this stage. I specified that a second IRB approval would be requested if and when my dissertation proposal was approved and my team members felt comfortable to volunteer as co-researchers. The initial IRB proposal and the consent forms were approved (Appendices B, C, D, E, F, G). The second IRB was submitted following a year of PAR collaboration after its continuation was called upon by PAR co-researchers. The IRB and consent forms were approved in June 2014 (Appendices I, J, K, L, M, N).

IRB for the dissertation collaboration. After five months of piloting the PAR team with its original members, the first of two IRB submissions was created to propose a participatory action research collaboration between myself (a Ph.D. candidate in Counseling Psychology, supervised by a faculty member in the TC Department of Counseling and Clinical Psychology) and a team composed of participants and staff at CMHC. This first IRB was decidedly submitted to request approval for collaboration with community-based organization service users as co-researchers. Unlike a typical IRB protocol, there was no research or recruitment for participants at the time of this first IRB except for the goals of promoting conversations on important issues

that are relevant to the co-researchers, drawing on each others' knowledge and concerns to foster connectedness and supportive relationships while exploring potential areas of research and social action. This first IRB explained that a second IRB would be requested when a research question is decided by the co-researchers and consists of data collection.

The first IRB. Having received the results of the TC IRB committee's deliberations, I approached the team regarding implementation of the recently approved IRB proposal. We took the time to review what an IRB consisted of along with the accompanying consent forms. We reviewed the consent forms regarding issues of confidentiality, rights, and responsibilities. It was emphasized to the participants that their decision to collaborate with a PAR team was entirely voluntary. They were reassured that they could withdraw from the PAR team at any time they wish, with no prior notification necessary and the freedom to enroll in other groups with no negative consequences whatsoever resulting from their decision to discontinue. In terms of confidentiality, the IRB outlined that all participant/ co-researcher information would be held confidential and pseudonyms would be given and used in all reports. If a participant/ co-researcher were to request to be an identifiable member, a conversation would take place between the co-researcher, facilitator(s) of the team, the Director of PROS, the Director of outpatient psychological services at CMHC (both of whom are licensed psychologists), to discuss the choices and implications that the co-researcher would like to make.

The transparency of this consent process afforded the team an opportunity to clarify information that research investigators often took for granted. For example, our team members expressed being unaware of the ethics and procedural mechanisms in the protection of the rights and welfare of research participants. This process continued whenever new members joined the

team. All team members eventually shared an understanding of the purpose and goal of the IRB and volunteered to participate in the collaboration.

The second IRB. Following a year of successful collaboration in the initial phase of the PAR collaboration at CMHC where a team of ten co-researchers was assembled and have together identified an area of research interest, a second IRB was submitted to carry out phase two of the collaboration that would last from June 2014 through June 2015. Phase two aimed to further solidify actions related to developing the research questions, designing methods by which to address the research objectives, collecting information, and taking action as informed by the data. All other parts of the consent forms regarding issues of confidentiality, rights, and responsibilities remained the same and were thoroughly reviewed with the co-researchers through ongoing basis. All co-researchers volunteered their continuation in the collaboration.

Communication with the treatment staff on the approved IRB protocols. The PROS treatment team also reviewed the approved IRBs. The staff conveyed excitement and support to the PAR project as they expressed hearing positive feedback regarding the development of our collaboration with the PAR team participants. Upon review of the approved IRB, attention was placed on encouraging the counselors of each PAR participant to facilitate a safe space to communicate their thoughts and reactions to PAR, as well as on issues that the participant may want to address outside of the group privately with their counselor. Furthermore, I encouraged openness between staff and participants regarding alternative programming (if desired by the participant), and to emphasize that their participation in the group was to be completely voluntary, and that their refusal to participate or withdrawal at any time would not result in jeopardy to any of their entitlements (medical care, employment, student status, etc.) within or outside the agency. The staff was also informed that they did not need to disclose the

participant's reason(s) to withdraw from the group if the participant wished to have their decision kept confidential.

Establishing a PAR Collaboration: Steps and Stages Based on The Current Project. The list below summarizes the action steps that were taken to build the PAR collaboration at CMHC.

Setting the stage for PAR: Exploratory and pre-project work

1. Build a relationship with the community-based or other agency with whom you wish to collaborate via outreach, volunteer work, and/or practicum affiliation.
2. Identify academically- and agency-based supervisory support for yourself during the PAR collaboration.
3. Learn about the population, mission, culture, staff, and operations at the agency and understand the relationships among the stakeholders of the agency. Explore how PAR could support the agency and its stakeholders.
4. Examine how PAR could fit within the structure and format of interventions provided by the agency and plan to create a PAR team that is feasible within the structure of the agency.
5. Create a proposal containing information about PAR and general overview and purpose of implementing PAR activities. Gain approval from the managerial board of the agency.
6. After approval of a PAR implementation at the agency, review and the project and PAR mission with staff.

Pre-project and IRB-approved phases of the PAR collaboration

7. Aim to create fair, informed, and transparent consent for PAR team members through experiential involvement of the PAR collaboration by submitting a pre-project IRB to request approval for collaboration with participants as co-researchers and *not* as research subjects. Specify that a second IRB approval will be requested if and when the team's potential

activities (and the dissertation proposal, when applicable) has been approved by PAR team members who feel comfortable to volunteer as co-researchers.

8. Discuss recruitment approaches with staff following IRB approval.
9. Begin pre-project phase of PAR collaboration with team members. Engage in a reflexive dialogue of issues that members deem essential to their community and well-being. Promote critical discussion through the use of formal and informal activities and negotiate areas of research.
10. Submit second IRB for approval after community members affirm that informed consent has been achieved and when they decide to volunteer in the project as co-researchers.
11. Continue PAR partnership following IRB approval. Plan and enact meaningful activities that contextualize specific strengths and problems as experienced by PAR co-researchers. Engage in activities that promote research techniques while simultaneously engage in critical praxis to narrow down research topic.
12. Execute research techniques on the research topic as determined by the co-researchers. Take action with co-researchers toward personally and collectively meaningful change (i.e., disseminating the research outcomes, creating solutions to the examined issues, etc.).
13. May need to re-submit IRB approval if collaboration extends beyond a year.

Diagram of action steps carried out with PAR team members/ co-researchers during team meetings.

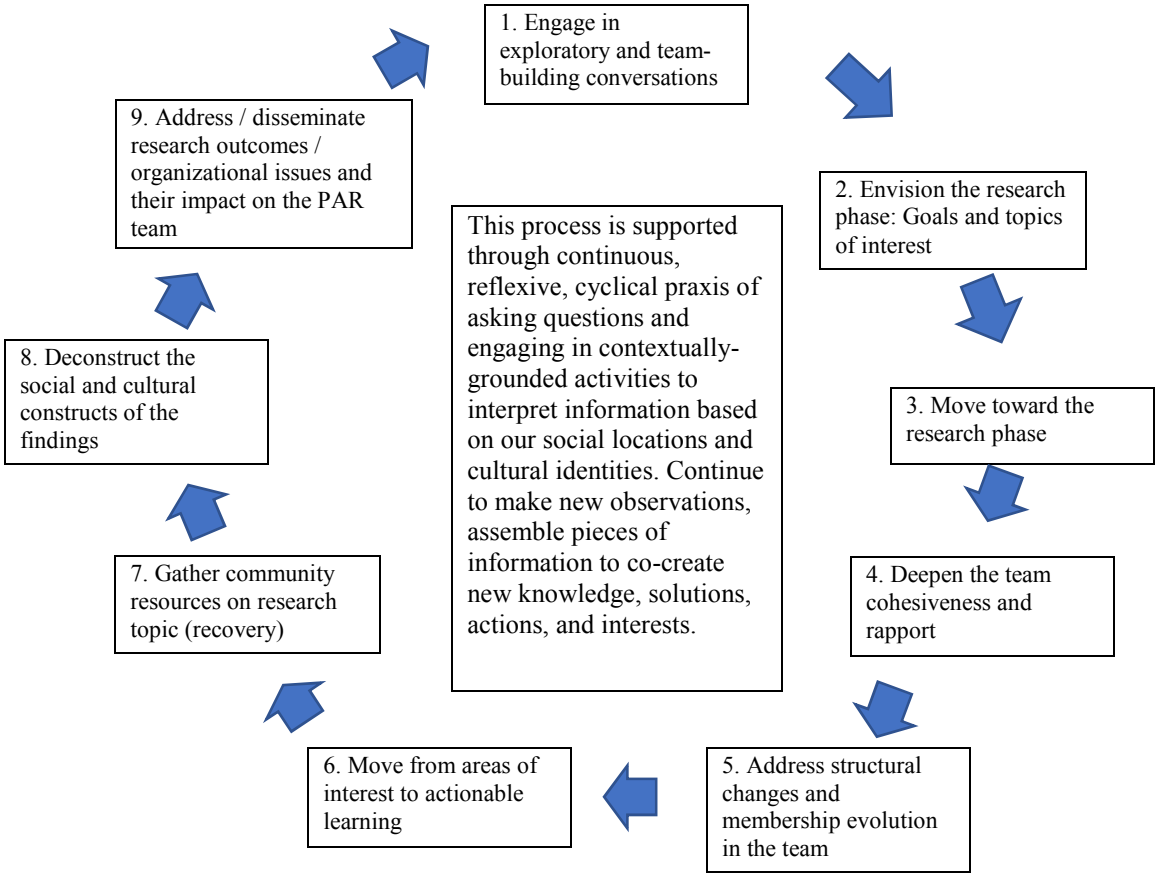
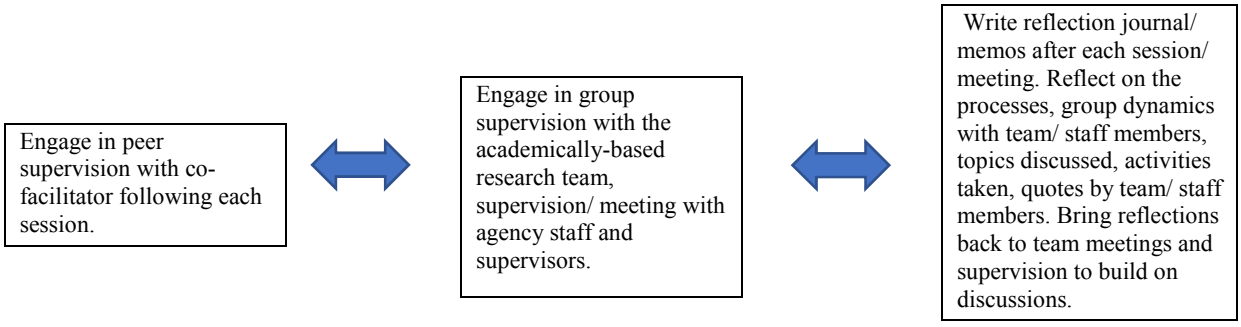


Diagram of action steps carried out by (co)facilitators outside of PAR team meetings.



CHAPTER IV

RESULTS

The PAR collaboration at CMHC consisted of numerous action steps, some nuanced and some grander in scale, which was executed to foster social transformation and conditions of equality for Chinese immigrants diagnosed with serious mental illness. Several projects were achieved from the two and a half years of collaboration. The major projects were intertwined with numerous action steps taken by the team of co-researchers that were novel and unprecedented at the agency. The actions and practical outcomes formed the bedrock of trust, cohesion, support and confidence in the team and the co-facilitators to make meaningful contributions that propelled the team to aim for greater change and lasting endeavors in the agency.

The results of a PAR project involve all these components – multiple series of action steps interspersed with discrete projects, all woven together within a fabric of members' own process and development as a team. Obviously, such results cannot be conveyed in the succinct, tabular form that is available to more conventional undertakings. One approach to reporting PAR results is the use of a narrative framework that recounts the unfolding development of the team's work as it highlights major landmarks along the way (Smith, Rosenzweig, & Schmidt, 2010), which will be the approach utilized in the present study. Therefore, after a brief overview, the team's work will be profiled via a narrative section that presents team events in chronological order.

Overview

The reflexive process of PAR involves engaging in critical comprehension through interactive conversations, participating in formal and informal activities that contextualize

specific strengths and problems as experienced by the population, negotiating the areas of research, and taking action toward personally and collectively meaningful change. As will be described, our team's undertakings were grounded by the circumstances of the problems identified by our co-researchers, and ranged from group-level interpersonal reflective processes to actions that examined the intersectional issues of mental illness, polytrauma from the onset of symptoms, treatment, and treatment repercussions across the co-researchers' social systems, examination of the intersection of power and privilege within multiple social identities (race, gender, psychiatric disability, immigration, social class), and actions taken to overcome systemic barriers confronted by the co-researchers, their families, and treatment staff. Various methods were learned and applied to accomplish projects, some smaller scale and some on the agency level, that further deepened our understanding of how the interplay of the multiple social labels and identities manifested in the co-researchers' everyday life. Although the series of events that occur for the co-researchers may appear mundane, easily done, and insignificant for those of us who fall within the norm of mainstream Western culture, our co-researchers have repeatedly expressed the novelty, value, rarity, depth of knowledge, and interpersonal connection gained from the small action steps that they were traditionally excluded from taking.

The method for each project and/or action was selected per its appropriateness in achieving the short-term and long-term goals that were delineated by the co-researchers. For example, photovoice, a process that uses photography to promote community representation and identity, critical dialogue, and knowledge about community issues to bridge essential discussions to stakeholders (Wang & Burris, 1997), was considered effective for exploring and documenting uncharted territories such as the gentrifying neighborhood of South Street Seaport. Social gatherings in the community, such as visiting local cafes or the public library, were frequently

advocated by the co-researchers to counteract routine perspectives that had come to be focused on treatment and symptom management within the confines of day programs, hospitals, and medical clinics. Other times, the co-researchers deconstructed their circumstances by identifying concerns and problem-solving or building on practical knowledge to the questions that puzzled each other by reaching out to respective staff or seeking available resources in the community. This has included hosting meetings with the Director of PROS to address the co-researchers' concerns, such as keeping the PAR program following my termination or finding out the operations behind hiring new staff, and inviting guest speakers to speak on practical matters related to recovery (i.e., managing gainful employment and maintaining Social Security eligibility).

In presenting the results of the team's work together, the implementation of this PAR team's process will be organized according to a series of working stages named for the primary characteristics of the group's process during that time. These stages are indicated by headings and subheadings, and they consist of exploratory, project-oriented, and team-building episodes that are outlined below. Following this introductory profile, these elements will be discussed in greater detail.

Engagement of team members as co-researchers. During this period, the team worked on understanding the meaning of participatory action research and its egalitarian approach towards building self and community awareness on our social identities and the impact of serious of mental illness through dialogue and unconventional methods that promote critical inquiry with the aim of creating systems-level transformations. This phase also entailed an opportunity for the co-researchers to begin calling into question the social and political influences on the community's understanding of people labeled with serious mental illness and their micro-level

manifestations in the co-researchers' everyday lives. The process was also comprised of activities and discussions that examined the concept of power and privilege in the context of our co-researchers' everyday interpersonal transactions that maintain the superior position of authority figures and the inferiority of marginalized individuals.

Envisioning and moving toward the research phase. To begin conceiving research topics, the team embarked on investigating systemic and social influences that have had profound effects on the co-researchers' lives. The issues discussed included institutional and policy changes in mental health services, the intersections of serious mental illness diagnoses, discrimination, unemployment on the population, and power and privilege in research. The team also engaged in learning about research methods by discussing various research practices and applying them, such as developing a survey and photovoice.

Deepening team cohesiveness and rapport. This period was comprised of the co-researchers cultivating stronger interpersonal connections, shedding light and privileging voice to their collective experience. The team members achieved this by exploring concepts related to power, privilege, recovery, social identities and roles within group settings as we shared personal stories and examined structural issues that affected the team in the here-and-now. The team also expanded on its dissertation collaboration, clarified the consent process, and began narrowing the research topic following the foundation developed from the deeper interpersonal connections.

Structural changes and membership evolution in the team. This period was marked by changes in the agency and the team's collaboration to help ensure successful operation of the group. The collaborations included recruiting new members, building connections in the community, and identifying and carrying out action steps to attaining vital resources such as

Social Security with the goal of the co-researchers gaining practical skills to achieving greater autonomy and control over their recovery process.

From areas of interest to actionable learning. The team identified the subject of Social Security status to be an area that could benefit from research and action. The team members sought out various practical and creative avenues to finding out the answers and resources to the questions and concerns regarding navigating issues related to employment and social security. The research process elucidated cultural expectations behind the use of Social Security while gaining practical knowledge on methods of maintaining Social Security. The team members found this initial research experience to be positive and informative, and directly facilitated their ability to make autonomous decisions in the vital area of Social Security, employment, and recovery.

New year, new members, new goals. The new year presented an opportunity for the team to explore the sociocultural influence of current events as they pertained to individuals with serious mental health symptoms. The co-researchers began gaining a deeper understanding of each other's journeys with surviving the traumas of serious mental illness diagnoses and treatment. The team members started building on group cohesion and identity as a result of sharing their identities, personal beliefs, strengths, challenges, and areas of growth. Revelations regarding meaningful change for the co-researchers and their community were further uncovered through reflective praxis. Wisdom gained from the plights and successes of the co-researchers' personal journeys were also further elucidated.

Gathering community resources on recovery. The co-researchers identified that the subject of self-help and recovery was an important research area for the team. Specifically, they wanted to seek out self-help techniques that promoted positive self-efficacy while managing

challenging social and environmental demands. The co-researchers gathered resources on the subject in the community, critically examined the literature and cultural application of the learned techniques, and invited guest speakers to expand their knowledge base on recovery, and propelled further examination of crucial subjects, such as the use of medication and the role of romance and intimacy in recovery.

Expanding our knowledge on the role of employment and other essential factors to recovery through a survey development. The team embarked on constructing a survey to examine employment issues that were experienced by the population and methods to improving vocational access at PROS. The co-researchers developed hypotheses and engaged in several rounds of editing and narrowing down the survey questions. They also prepared for survey dissemination and implemented program-wide survey dissemination.

Examining the results of the CMHC survey. The co-researchers explored the outcome of their hypotheses and survey data. They discovered valuable information regarding the demographics of their survey participants, the participants' preferred hours of employment, concerns around managing responsibilities outside of employment, obstacles to attaining successful employment that the participants would like more assistance with, and areas that PROS participants believed could benefit from further examination by the PAR team.

Deconstructing the social and cultural constructs of the findings. The team engaged in further analysis of the survey outcome by deconstructing the social and cultural constructs of the research findings. The co-researchers specifically examined the concepts of: gender; age; education; preferred hours of employment; managing responsibilities outside of employment (i.e. treatment and non-treatment-related responsibilities, entertainment and family); and barriers to employment (i.e., nervousness and anxiety around novel situations and environments, mood

symptoms, traffic/ commuting issues, behavioral issues, fatigue and drowsiness, decreased memory and cognitive ability, delusional beliefs and voice-hearing, and language barrier). The team also explored the sociocultural reasons to the participants' feedback on relationships that were pertinent to their recovery as well as the benefit of more research on relationships.

Organizational changes within the agency and their impact on the PAR team. The team addressed organizational challenges that emerged during this period. The issues included the resignation of the PAR team's co-facilitator, the increased number of counselors resigning from the organization, and the overall effects those resignations were having on the PAR team and across the agency. The PAR team worked on various tasks to ensure that the co-researchers' voices were represented in the agency's decisions. As change agents, the co-researchers took on bringing on a new co-facilitator to continue, advocated for increases in communication and transparency within the organization, identified key goals and objects for the future direction of the PAR team as PROS was undergoing structural changes, and initiated the development of participant-driven programming.

Exploratory and Team-Building Conversations

In the following sections, the project phases introduced above will be presented in greater detail to include descriptions of team process and actions.

Engaging team members as co-researchers. The group began its first session in the second to last week of January 2013. We began with six participants (Jing-Jing, Grace, Patty, Amanda, Ah-Tung, and Ke-Ming) and two co-facilitators, myself and Jiang. Jiang and I initiated the PAR meetings with the aim of helping each member get to know one another. Our team members initially showed hesitation and expressed uncertainty regarding what deemed appropriate to share. We approached this newly developed group setting by emphasizing

openness, validation, and flexibility of what our team members chose to share, since unlike other groups, the dialogues in PAR aim to be democratically and pragmatically driven by the team members. The team explored the meaning of PAR partly through free associations of the images, ideas, thoughts, and feelings derived from the words *participatory action research*, and partly through my explanation of what PAR represented in multicultural psychology.

Throughout the exploratory conversations of PAR, the team members were encouraged to ponder areas of their lives that mattered to them and that they desired to understand further. As time went on, the members gradually began to do so. Our team members spoke about the importance of the PROS program, how it became a safe haven for them as they felt themselves to be outcasts of their community due to reasons such as: burden of mental illness stigma and limited places in the neighborhood where people with the diagnoses could gain support; limited financial, employment, and social resources; language barriers; trauma from the onset of mental illness symptoms and aspects of psychiatric treatment; and helplessness and hopelessness of the seeming chronicity and persistence of their illnesses ("One year turned into ten").

The rawness seen in what was shared by our members gave us glimpses of the countless injustices and oppression faced by them. And although we approached PAR with the best intentions to affirm equity and democracy in our approach to relationship-building, we were taught by our members' disclosures that we must honor the trials and tribulations in their journeys, and defy our urge to compensate or attempt to undo the pains of their experiences because of our own discomfort with the injustices of our laws and institutions. We learned that substantial amounts of time would be required to build the trust and assurance for ethical, authentically-occurring and community-driven research. This process also required us to challenge the biases and perceptions that were associated with our identities and positions in

society to understand the local wisdom of our co-researchers. A snapshot of notes on the PAR process gathered during a team meeting is attached in Appendix M.

Polytrauma from symptoms, treatment, and repercussions across the co-researchers' social systems. Our members began to speak to each other about what mental illness meant to them. They referred to media perceptions of mental illness, and about being seen as dangerous, violent, unpredictable, and bad-tempered. They stated that only extreme stories about mentally-ill persons are published, and asked, "What about people with mental illness who are calm and peaceful?" and "What about educational pieces about recovery and supportive resources for families embattled by mental illness?" Our co-researchers found themselves defying the common stereotypes of people with serious mental illness diagnoses that are depicted in the media, and being the ones subject to other people's hostility and aggression.

Barriers to romantic relationships due to mental illness label. Issues surrounding love were also explored in association with Valentine's Day. We examined social issues that were confronted by people with serious mental illness that were depicted by Amanda's current dilemma with a man. Her husband separated from her since the onset of psychiatric symptoms where she required hospitalization. Her husband openly engages in extramarital affairs yet refused to divorce. Amanda recently met a man whom she would like to pursue a romantic relationship. However, the man is an undocumented Chinese immigrant, and Amanda worried that she was merely used to gain legal residency. Amanda was further frustrated by her parents' lack of approval regarding her engaging in a romantic relationship despite her husband having abandoned her in an extramarital affair and yet refusing to divorce. Amanda expressed feeling powerless as a woman and as someone with a psychiatric disability. She felt that she had been socialized to accept blame for her past episodes of psychosis which therefore legitimized her

husband's infidelity. Our team members empathized with Amanda's experience of feeling undermined in her right to fidelity as a woman because she carries a mental illness label. The members also expressed frustration regarding others' tendency to discourage people with serious mental illnesses from pursuing intimate relationships or the misperception that people with mental illness labels are irresponsible, hypersexual, asexual and/or too debilitated to make sound judgments regarding issues of intimacy and romantic relationships.

Examining the concept of powerlessness among marginalized identities. The group continued to explore the meaning of PAR and the concept of holding power and authority. We engaged in an activity where we ranked everybody's positions at PROS regarding power, including psychiatrists, psychologists, social workers, nurses, receptionists, cleaning staff, interns, and participants. All the members ranked themselves as last on the list, claiming that although they were treated with respect, their entire well-being heavily depended on professional support; thus, they felt others held almost all the power over them, and they held the least amount of control over what happens to them and others. Our members' perceptions of their standing became a critical jumping-off point for the group to examine areas of their lives in which greater equality and power distribution were required, as well as possible methods for shifting the power.

We also explored the way in which we addressed one another. Our members had been calling us (the co-facilitators) Joyce and Jiang, even though we had been introduced to them by our first names. We explored the dynamics of PROS participants and clients typically addressing professionals in a formal manner whereas the participants themselves are addressed informally. Our team members expressed discomfort at the idea of addressing professionals informally and being misperceived as disrespectful and challenging toward staff. They explained their position

of often being misunderstood as dangerous, unpredictable, and problematic and therefore feels the need to compensate for their patient status by presenting as respectful, polite, compliant, and non-threatening as possible.

Conversely, our team members explained feeling uncomfortable being addressed with titles such as Mr. and Ms., because it did not suit their inferior status. They elaborated that they were "patients" and their psychiatric statuses did not warrant them to be addressed formally. We continued to explore the values and beliefs attached to having titles in our names and invited our team members to also address us (the co-facilitators) by our first names. Our members expressed hesitancy to address us informally in the presence of other professionals for fear of being perceived to be rude and offensive. However, they also believed that PAR was a place where we examine and challenge hierarchies to show that every person is valued and treated equally, and therefore wished to begin calling the co-facilitators by their first names.

Envisioning the Research Phase: Goals and Topics of Interest

Institutional changes within the agency and its impact on the team members' recovery process. In broadly exploring the topics and objectives that we would like to focus on in our group, our team members began discussing the treatment reform that occurred at CMHC when the Continuing Day Treatment (CDT) service was changed to the Personalized Recovery-Oriented Services (PROS) program by the NYS Office of Mental Health. CDT was found by our members to be more formal and activities were held in large groups in which all participants were engaged. With PROS, our team members found the greater variety of classes and smaller class sizes to be more intimate and designed for their needs. They also found that smaller classes made it easier for them to engage with each other and more aligned with the goal of greater self-expression, although at times they also felt too "visible," sometimes preferring more anonymity

so that they would not be as easily called upon by the group instructors/ facilitators. The members explained that they felt apprehensive in the large group setting and preferred not to speak, which resulted in awkward silences and feelings of shame and ineptitude. Although PROS created a friendlier and more relaxed environment, CDT received greater funding, which provided the participants more activities in the community, such as visiting museums, parks, restaurants, department stores, and carnivals. Our team members unanimously mourned the loss of funding and the social activities that the funding provided while expressing relief that treatment agencies were still in operation despite the funding cuts and wanted to find ways of incorporating more outdoor activities in PROS.

Examination of the intersections of serious mental illness diagnoses, discrimination, and (un)employment. Our team members understood their illness to be partially the result of the physically-laborious and difficult work environments (below minimum wage, job insecurity, and limited social interaction and satisfaction) paired with low satisfaction to which monolingual Chinese immigrants are restricted. Relatedly, they spoke of the accepted universality of the unsafe work conditions for poor, non-English-speaking Chinese immigrants. They described living and working in small Chinese enclaves, wherein news about a family with mental illness travels rapidly and employers are informed about which employee or work candidate bears a psychiatric disability, and they consequently become less able to be hired or maintain employment. The team members described that the work opportunity for PROS participants had been similarly low in status, typically janitorial (such as mopping floors, cleaning restrooms, washing dishes) and likely unpaid. For example, Patty and Grace were currently volunteering at a non-profit nursing home. They discussed experiencing a great degree of anxiety in their workplace, primarily for fear of "doing the wrong thing," "being unable to keep up," and

"performing badly," because they often feel drowsy -- a common side-effect of psychotropic medications. They also worried about being misperceived as "lazy" and being regarded by staff and their families as unmotivated or as deteriorating if they decide to discontinue the volunteer work. The constant lack of gainful and gratifying employment regardless of the changing circumstances have left PROS participants feeling perpetually disadvantaged and excluded from making meaningful and practical change in their recovery.

Moving Toward the Research Process

Exploration of the research process. The team now began to examine the research process after identifying broad areas of research interest (more outdoor social activities in PROS and employment). Members of my university research team had created a PowerPoint presentation for PAR teams that presented examples of various research methodologies and how to match them to goals, objectives, and research interests. Jiang helped translate the material, which was explored in the team meetings.

Our team members reflected on their past experiences with research, such as engaging in interviews and participating in town hall meetings. We explored personal experiences relevant to the research process. Ah-Tung shared his experience of participating in an extensive survey during his time in an inpatient setting. He described being interviewed for hours without being offered a beverage. The "lack of sensitivity" negatively impacted his perception of the researchers despite having been compensated monetarily.

The team members disliked feeling "exploited" by outsider researchers and identified key aspects to developing rapport when engaging in research with community members. Namely, they saw the need to prioritize the interpersonal relationship and having interviewees or research participants be treated as full citizens rather than robots who are not affected by the content or

process of research. The team members saw the need for the researcher to act as a host to the interviewee and offer accommodations rather than asking questions for the sake of gaining answers. For example, they saw that participants could be offered tea, water, coffee, and the room temperature could be adjusted to a comfortable level and breaks could be offered. They also identified the benefit of allowing the participants express their thoughts and reactions to the research as a method of addressing limitations in a study or improving further research.

Exploring power and privilege in research. The team continued to examine the theoretical differences between conventional research and participatory action research. We engaged in a discussion on who usually holds authority regarding the selection of research topics and the questions that are deemed important. We explored the notion that PAR brings to the forefront the community expertise and wisdom that conventional research often overlooks precisely because conventional research questions are decided by people outside of the community. This conversation evolved into issues of power and privilege in conventional research and how PAR attempts to restructure the power differential based upon the understanding that everybody can be both learner and teacher. We took the discussion a step further by examining the hierarchies in our environment and reflecting on who stands on the outskirts of core decision-making groups. The team identified particular types of people as the ones who typically have membership in prestigious and exclusive groups: those who were White, educated, wealthy, male, employed with high statuses at work, without mental illness, and who spoke English. As we deliberated on the identities and statuses of those who made decisions over this specific population, we were struck by the realization that the people who held authority over their treatment, needs, challenges, strengths, and resources likely have little cultural understanding and lived experience of the environments in which they and their families were

embedded. The members reported that they had little to no contact with the people that occupied the aforementioned identities. These discussions illuminated for the team the significance of community members conducting experientially grounded research and the power of those projects to have a direct impact on the community.

Practicing the application of research techniques: Considering a survey. As we began relating our examination of the research process to the topics that our team members had found crucial to their recovery, we identified physical fitness as an interest. We decided to use this topic to practice developing a survey to reflect the techniques we had been discussing as possibilities for the research component of PAR. Our team members saw benefit in creating a survey with multiple choice options, as they found it less burdensome to have choices listed than to require the respondent to self-generate answers. The team wanted to find out about the types of sports or physical activities that PROS participants were most interested in, the types of sports or physical activities that were feasible at the program, and the times when exercises are most ideal within the treatment schedule. Multiple choice questions were created in response to the team's curiosities. The team members found the experience of developing a survey to be less complicated and more informative than they had expected, although they still felt skeptical about themselves as researchers and the utility of them asking the questions rather than the experts.

Practicing the application of research techniques: Photovoice. The team decided to visit the newly-constructed seaport at Pier 17 in response to the team members' desire to engage in more outdoor activities. We decided to double the purpose of exploring our community with applying the research method of Photovoice. Photovoice is a process that uses photography to promote community representation and identity, critical dialogue, and knowledge about community issues to bridge important discussions to stakeholders (Wang & Burris, 1997).

None of our team members owned a camera or smartphone, but they expressed interest in using cellphone cameras, and had agreed to take pictures of the community and not of people or each other due to privacy considerations. We spent some time learning how to operate the camera functions. Afterwards, we set the goal to take photos of our community that triggered "happy" and "sad" emotions.

Many photos were taken of the surrounding and changing landscape of the South Street and Pier 17 area. The community had undergone considerable gentrification. Our reactions to the new constructions and neglected areas of the neighborhood triggered a range of emotions, questions, and perspectives that the team members processed with one another. From appreciating the changes to recognizing the wealth disparity, gentrification and rising prices of the neighborhood, our co-researchers gleaned from this experience that a range of emotions and perspectives could be captured with the same photo. They were surprised to find no “objectivity” in their data as each photo triggered a different reaction for each of them, all uniquely personal and important. Our team members experienced this research method conducive to capturing intimate details of their community and promoting conversations that encouraged divergent viewpoints and helped build a broader and fuller understanding of the impact and changes to their environments.

Deepening Team Cohesiveness and Rapport

Preparing for a change in co-facilitator. Spring 2013 was comprised of a time of celebration for the New Year and sadness regarding the imminent departure of our intern co-facilitator Jiang, who was accepted into an out-of-state doctoral program. Our team members found Jiang to have been a great addition to the CMHC staff and opted for the PAR team to continue with the addition of a new co-facilitator, Tao. Tao was a counselor at CMHC for

approximately five years and currently enrolled in the Master of Social Work program in the city. She had begun learning about PAR and had expressed a passion for applying PAR at PROS. Tao joined the PAR team in May 2013.

Exploring power and privilege in our identities and in our group processes. As we continued to deepen our exploration on all fronts of the educational, research, and critical consciousness-raising process, the team also extended the conversation to the interpersonal arena of this PAR team through the team members' social identities and sociocultural locations.

Patty's story. We learned from the group reflections that, because of her younger age relative to other PROS participants, Patty was inclined to take on a more passive and agreeable stance in her relationships at the agency, as cultural beliefs have defined her life experiences to be inferior compared to older individuals. Patty also identified her psychiatric label as playing a salient role in the way she engages her environment. She had struggled with checking and repetitive behaviors, such as frequently locking the doors and windows to her apartment.

Patty also believed that her unemployment and poor social class status played a salient role in how she understood her self- and collective- efficacy. She reminisced about the times when she was able to find work at garment factories, and the livelihood offered her the ability to play an autonomous role in her financial decisions, while fulfilling the cultural expectation of supporting her family. Numerous garment factories have shut down since 9/11, and her symptoms exacerbated as her occupational outlook worsened; eventually, she required fulltime commitment at the day treatment facility. Patty described her social world as caving in as she became more excluded from participating in it through ways that allowed her to feel like a citizen rather than a patient. The perceived loss of control translated into obsessive thoughts and need to protect herself from further disenfranchisement.

The team members commended on her willingness to express herself more spontaneously and vulnerably, which contrasted starkly with her previous reluctance to share information with her peers for fear of revealing insecurities that others could exploit. Patty explained that she has learned to let her guard down with the PAR team, stating, "I notice that I always feel better after talking about things that I don't know [in this team]. I learn and laugh with this group, and it makes the subjects easier to talk about with Dr. Kan (her psychiatrist)."

Ah Tung's story. Ah-Tung saw his race, immigration, disability and social class statuses carrying the most salience relative to his interpersonal relationships. He described feelings of shame and learned helplessness from the restriction and lack of impact his decisions have made on his recovery, ability to find employment, and as an immigrant who struggled to access resources. He reflected on his perceived loss of self and control during symptomatic periods, such as developing irrational fears, false beliefs, hearing voices, and feeling persecuted for being an Asian immigrant. These symptoms caused him incredible paranoia and fear of the world. He became afraid of sleeping in his room and of consuming food, as he believed he was being poisoned and spied upon. Ah-Tung also talked about his past wrist-cutting behavior, which he reported had helped bring him more in touch with physical reality and in control of his senses.

Ah-Tung expressed sympathy for his old self as he looked back in time. He shared experiences of pain and distance from family members since the development of his illness. There had been a significant change in the quality of his relationships with his siblings where he eventually became restricted from interacting with his niece and nephews. He believed that the social distancing was caused by prejudice against someone with episodes of psychosis who was perceived to be violent and unpredictable. He spoke of rare opportunities where he could still

experience dignity, such as when his younger brother bought him a pack of cigarettes when he requested it, which symbolized having some face and authority as an older brother.

Within the PAR team, Ah-Tung saw his male status as well as longer treatment at PROS playing a more salient role in his approach to discussions in the PAR team. He was the most vocal member of the group. He saw his increasingly active participation as a result of feeling safe and supported in this team. However, he was aware that the sense of safety may stem from being the only male member of the group at this time and that he had implicitly steered and asserted power over the group topics. The female team members validated the observation that he shared the most in the group, but they saw his sharing as conducive to creating a supportive environment and welcomed his sharing.

Grace's story. Grace shared that her age, gender, and disability statuses played salient roles in her identity and social interactions. As an unmarried woman in her forties who had been in treatment for 20 years, she had assumed the caretaker role for her family and at PROS. Grace shared that contrary to the PROS participants' and team members' perceptions of her currently good health and leadership, she was "very sick" before her immigration to the U.S. Her symptoms included intense fear and paranoia of others' persecution of her, such as her colleagues plotting against her. Grace described how the combination of active persecutory beliefs and the delusional belief that she was an invincible superhero contributed to her history of attempting to jump from buildings. She attributed her recovery to the social support she had gained from treatment settings, as well as finding meaning from building positive relationships in her home and her social environment.

Jing-Jing remained mostly quiet when the PAR team members talked about the traumas of their past symptoms. She opted out of talking about the specifics of her past struggles but

mentioned that she used to be a nurse in China before she struggled with insomnia. However, she contributed by writing the team members' ideas on a poster as the team decided to begin recording lessons and pearls of wisdom gained from their recovery process.

Examining lessons from our recovery. The group identified essential lessons learned from their recovery process. They saw the vital role of social support and ongoing involvement from caregivers in forming emotional connections with people diagnosed with serious mental illness, regardless of the person's possible seeming rejection of the help. The team members also saw the importance of family members receiving emotional or professional support and psychoeducation to learn how to effectively cope with and support their loved one's recovery, as they had seen the perils of falling into greater isolation when caretakers misunderstood the illness. Furthermore, the team members identified the significance of psychoeducation and counseling offered by treatment providers to assist with therapeutic compliance and one's commitment to treatment. Our team members described how easy it was to fall prey to negativity and extreme self-doubt. Therefore, they emphasized the need for a place to rebuild one's self-esteem and manage challenging emotions with the help of supportive individuals who are well-informed about mental health.

Consolidating the dissertation collaboration and consent process. At this point, the team had met for six months, a period during which they had had the opportunity to consider the possibilities of PAR projects and to experience the dialogue that typifies team meetings. I hoped to propose a formal PAR collaboration with the CMHC team in fulfillment of my dissertation work, and CMHC staff and I believed that the team was now at a place where we could purposefully consider the proposal and whether or not the team members would like to go forward in that vein. The full details of that consent process were reviewed in the preceding

chapter. Following the completion of this process, the team entered a new phase of group membership, building community relationships, narrowing the research topic and carrying out the research process.

Structural Changes and Membership Evolution in the Team

In light of a staff shortage at CMHC PROS, PROS reviewed the decision to allot two co-facilitators to the PAR team, and explored the possibility of retracting Tao for other program responsibilities. The team members expressed understanding of the concern although both the team members and Tao wanted to remain in PAR. We brainstormed solutions and saw this to be an ideal time to recruit new participants to address both the PAR team members' desire of including more participants and to fulfill PROS' criteria that two co-facilitators are only assigned to larger groups. To begin the recruitment, we brainstormed and practiced speech material that we would like to be communicated to prospective PAR participants. We successfully implemented the plan and invited three PROS participants, Lai-Do, Ming-Zuo, and Ge Li, to sit in on the PAR sessions before committing to the team. PROS also referred a new participant, Bai-Hua. During the next few weeks, we talked over what PAR means, the ideas and formulations developed for research thus far, and hopes and expectations that the new team members might have for joining the team. These discussions marked a period that brought new and existing team members together on the same page.

Fortifying social relationships and our connections to the community. The original team members wanted to welcome the new members by engaging in a field trip to a local Cantonese café in the neighborhood. Grace and Patty recommended the venue. All but one team member attended. At the restaurant, our co-researchers all preferred to be seated in the back of

the room. Most of the female team members appeared quite relaxed while the two male team members appeared less comfortable during breakfast.

After returning to the agency, the team processed thoughts, feelings, and general reactions to the community excursion as a new team, given its new and unique membership. Ah-Tung expressed excitement for being "connected with the modern and social part of the world" and "participating in activities that [he] only [saw] on TV." He was surprised that he could engage in this activity at relatively low cost. Patty expressed contentment and validation for successfully carrying out a plan with the team that was suggested by her. Ming-Zuo shared that he generally enjoyed the excursion although he felt nervous around strangers for fear that he was carrying himself awkwardly and made others feel uncomfortable and threatened by his presence. Other team members expressed similar sentiments regarding feeling guilty of offending others by looking like a "patient" and being in public rather than being out of people's sight and awareness while simultaneously fearful of inciting violence and placing themselves in danger. While the team members unanimously agreed to feeling worried that they could be subjected to violence and discrimination, the team members felt informed by the experience that they could feel safe together and have a pleasant experience despite the novelty of the experience. In addition to finding this to be a satisfying and informative experience -- as our team members found themselves being treated well by the restaurant servers while trying a delicious local Cantonese style breakfast -- they also realized that those of us labeled as "patients" could be just as effective as the others at identifying growthful and powerful activities to promote recovery and connectedness with their peers and the community. Having been changed by this experience, Bai-Hua stated,

> I was watching the way people looked at us on the streets and the way the servers and customers looked at us in the restaurant. Everybody seemed busy with what they were doing. They did not pay anymore attention to us because we were people with illnesses. The servers were polite and attentive. Patty and Grace picked a great restaurant. It was very affordable too. I liked the experience. I thought I would regret coming out and should have stayed in the clinic.

Promoting action and resilience during times of disappointment: identifying and carrying out small action steps. As we continued to build cohesion in the team through narratives on treatment areas that we would like to improve, team members saw that learning about the process of attaining Social Security whilst finding employment could be a highly practical method of gaining greater autonomy and control over their recovery.

From Areas of Interest to Actionable Learning

We began unpacking the issues that interested team members in order to identify small actionable steps. We identified immediate issues that our team members wanted to find answers that could represent the journey of regaining full personhood. The team members had questions pertaining to 1) the exact location of the Social Security office; 2) how to retrieve the most information regarding Social Security; 3) the risks related to employment as an SSI recipient; and 4) the phone number of a Social Security office. We identified resources that could help us figure out the answers. It was decided that approaching the vocational therapist might be most effective at the moment, and indeed, we were provided the answers immediately. This may have appeared to be a small action step, but our co-researchers expressed that these small action steps were the necessary means to building real trust towards the legitimacy of the team members'

concerns, the team's objective of being involved in every step of the decision-making process, and creating a sense of ownership and control over life circumstances.

Seeking out community resources. The team also decided to invite officers from the Supplemental Security Income and Social Security Disability office to offer more information on the implications of psychiatric disabilities, employment, and Social Security. The team deliberated extensively with regard to the details of the event, such as the time where the most number of staff and PROS participants would be available to attend, the location, and questions that we would like to explore with the guest speaker.

Brainstorming questions, concerns, and co-creating knowledge to navigate issues related to employment and Social Security. We began investigating the issues that we would like to address with the invited expert. Our co-researchers considered the ways that the stigma of their illness, immigrant status, and language barrier have restricted them from accessing gainful and fulfilling job opportunities.

One concern raised by our co-researchers is the possibility of their medical and psychiatric information being made publicly accessible through the internet. We used the opportunity to discuss the HIPAA law, the protection of patient information. We also discussed our rights to access our own health information, make corrections, and decide who gets to see what information. This discussion offered the team the opportunity to help our team members find closure regarding their employers being restricted from accessing their personal health information.

Our co-researchers also worried that their impaired attention and memory, restlessness, and akathisia (tremors) in the hands and legs could give away their psychiatric status to employers and result in termination. David, who was previously enrolled in the Ticket to Work

program, explained his experience with the vocational training and eventually becoming qualified for a job within the employment network. He saw this network as effective in bypassing the team members' concerns regarding employment discrimination because these employers participate in the network with the intention of hiring participants from the training program. David withdrew from the program due to the challenges he experienced as being the only Chinese worker at the job site. He experienced cultural and language barriers to forming relationships with his colleagues. He believed that the employment prevented his access to social connections that have proved crucial to helping him battle with paranoia, persecutory beliefs, and voice-hearing. Therefore, he opted to engage in a day treatment program for Chinese participants instead. Another matter that our co-researchers wished to bring up concerned having their Social Security revoked if they were able to secure a job. They wanted to know the logistics of this, as they feared financial constraints that would cause further burden to their families.

Elucidating cultural expectations behind the use of Social Security. A specific element of Social Security that posed significant concerns for our co-researchers entailed eligibility for food stamps following employment. Food stamps have alleviated the financial strain on our team members' families. However, it was also a source of ambivalence, in that it symbolized the inability to earn money and purchase food and thus held the cultural meaning of the incapacity to support one's family and help its members prosper. Our co-researchers described the feeling of great disgrace when they began receiving food stamps, feeling that it symbolized losing the right to engage in adult roles and major social exchanges. They saw it as indicating that they could not achieve the pre-requisite credibility, such as financial or earning power, to become somebody's husband, mother, provider, or caretaker. The perceived loss in status was reflected in the way our co-researchers found themselves treated in public settings, such as receiving non-charitable

responses when they inquire whether food stamps are accepted at certain stores, and experiencing second-class treatment compared to customers who do not use food stamps. As Ah Tung described, ‘I really had no choice before turning to Social Security. I didn't want to be a recipient. I'm scared when people see me using my [benefit] card. It means that I'm sick and unworthy.'

Gaining practical knowledge on methods of maintaining Social Security. Tao and I served as interpreters on the day of the workshop with an English-speaking guest from the Supplemental Security Income and Social Security Disability office. We gained new information regarding the security program containing built-in protection that incentivizes an individual to gain employment and receive a deduction in the disability, but the total income amounts to more than if the person were only receiving SSI or SSD. We also learned that there was flexibility in terms of the duration, type of vocational and educational options, and decision to stay or withdraw from the Ticket to Work program. A snapshot of our notes gathered during the talk on SSI/ SSD is attached in Appendix N. As the team debriefed this workshop, we found that it served as an important milestone for the team to arrive at a satisfactory outcome that addressed our concerns and offered practical advice. Our co-researchers expressed that this experience was a salient moment that resulted directly from voicing their needs and collective efforts. As Patty attested, ‘These [actions] were very helpful. They helped me learn more about SSI and how to maintain the benefits.’ and informative experience that emerged directly from identifying our needs, mobilizing our resources, and learning crucial facts that facilitated making autonomous decisions on their recovery.

New Year, New Members, New Goals

The group reconvened in the new year of January 2014 after two weeks of winter holiday. We discussed New Year's resolutions, current events, and recent changes that had occurred. Our co-researchers were eager to continue raising awareness and gaining knowledge on issues that were of concern to their recovery and learning solutions to meaningfully improve their conditions.

Sociocultural influence of current events and serious mental health symptoms. External influences guided a series of discussions as we entered the new year. We explored the upcoming Chinese/ Lunar New Year, the most important holiday in the Chinese culture. We discussed Chinese New Year traditions and activities that our co-researches practiced. Almost all our co-researchers described cleaning and decorating their homes and hosting large family meals that must contain fish to symbolize surplus and prosperity. Some co-researchers participated in traditional Buddhist rituals, such as burning incense and visiting temples to honor the Gods, asking for their assistance with overcoming struggles in the new year, as well as paying respect to ancestors and asking them for guidance and protection.

A glimpse of our past—Tina's story. While some co-researchers endorsed religious practices for the new year, Tina described herself being a highly devout Christian in the past, but her religious faith completely shifted since the onset of her illness. She initially turned to Christianity to seek solace from family conflicts. As the family conflicts worsened, Tina began hearing voices and having persecutory beliefs of God condemning her to burn in hell. Tina became paralyzed from the symptoms and struggled to keep up with daily routines. She became so fearful that she often isolated herself in her bedroom for days. She described the experience as highly traumatic and extremely confusing as she was placed on involuntary hospitalization. She decided to abandon the faith as her symptoms remitted. One method of healing for Tina since

emerging from her most severe episodes has been directing her attention to more pragmatic methods of achieving tangible needs.

A glimpse of our past—Bai Hua's story. Bai-Hua also shared her experience of persecutory and paranoid beliefs. She described a history of feeling surveilled and in complete loss of control. She thought that her husband was involved in plotting against her. Bai-Hua spoke about the effect of prolonged stress of unemployment on her family. She described that the pervasive sense of helplessness to lift her family out of poverty likely gave root to her feeling conspired against. She found her world spiraling out of control as her husband similarly suffered from unemployment, as the family relationships deteriorated, her psychological symptoms worsened, and sense of shame and social isolation deepened. She felt that the only way to relieve herself and the family of the burden was to commit suicide. Bai-Hua ultimately recovered from her suicide attempt by self-stabbing. While she continues to be haunted by the traumatic events, she described finding solace from being involved in a treatment program where she could depend on finding the appropriate support for herself and her family.

Bai-Hua expressed that this was the first time she shared her story in a group setting. She explained being inspired by Tina's bravery to talk about her experience and wanted to offer her solidarity and trust in the group. Tina in response expressed that she was willing to share in this group because the team has taken numerous actions thus far regarding her concerns, thus consolidating her trust that whatever is said in this group meant something and would be taken seriously.

Building on group cohesion and identity. Given that it was the month of the Lunar New Year, our co-researchers opted to participate in activities and discussions that promoted group cohesion between the new and original PAR members. We engaged in discussions that propelled

our understanding of each other's identities, personal beliefs, strengths, challenges, and what team members hoped to gain. Our co-researchers named the following facets of recovery as important for them to explore within PAR. A snapshot of the concerns discussed in the team meeting is captured in Appendix O.

- "We are the neglected ones in society. But I don't to be helpless. I want to feel more capable and in control." – Ming Zuo
- "I am not violent. I am kind. I want to volunteer and help even though I receive Social Security. I am a hard worker and I want to contribute." – Patty
- "I have a strong will to survive, but I wish to be more autonomous and learn to be more optimistic." – David
- "I am a very helpful person. I like to inform my peers and keep everybody informed. But I would like to learn to communicate my emotions better." – Grace
- "I feel like I have no confidence. I hope to develop more confidence and vocational skills" – Ah Tung
- "I am very skilled with household tasks, but I want to learn to be more communicative." – Ge-Li
- "I no longer feel as doubtful about taking action and engaging in research. I want to learn and know more about what is happening around me."—Bai Hua
- "I gained a lot of experience. It is important that we celebrate our recovery as we understand it and recognize all the hard work that we have put in."— Grace

- "I have a lot of skills and I am a hard worker. I still want to learn English." – Ah Tung
- "We can teach others who are earlier on their path to recovery with our experiences." – Tina
- "I want to learn to be more expressive and be better able to communicate with others." – David
- "I am not a lazy person. I just need to learn that I could take more initiative." – Lai-Do

Check-in from the director of the CMHC Outpatient Clinic. During this period, the director of outpatient services at CMHC attended one of our PAR groups to directly check-in with the members and gain an update on the PAR team. Our co-researchers opted to use the opportunity to discuss with the director the value and significance of the PAR team to them, as well as their process of identifying personal and group identities, strengths, needs, and challenges. The director expressed her support and appreciation for our co-researchers engaging in difficult but important dialogues to champion change for themselves and the community. Despite having rarely experienced meetings and open dialogues with a senior staff member within the intimate format of a group, our co-researchers expressed feeling validated and invigorated from the director's direct support regarding seeking personal change and collective change.

Seeking answers to our research question through reflective praxis. "Recovery" had become a broad topic of interest as we continued to explore how our personal goals could be achieved while addressing our shared commitment towards creating meaningful change. We embarked on a literature review to gather information on the topic and inform our knowledge base as we attempted to narrow the subject area.

Stereotypes and safety – achieving group goals versus protecting ourselves from possible discrimination during knowledge acquisition in the community. As we decided on places to gather information, some members expressed ambivalence and concerns about the risks that public activities post upon them. Our co-researchers' revealed that their diagnoses and mental health conditions were kept secret from individuals outside of their family and clinically therapeutic settings. As individuals who carried highly stigmatized labels, they worried about becoming identifiable as a person with mental illness by friends and acquaintances in the community because of how they might become triggered by their surroundings and activities. Our co-researchers grappled with the dilemma of taking risks and expanding their social environment versus taking a protective stance of their current situation. Tina described the emotional struggle:

> I've seen people with mental illness on the street. Other people could probably tell that I have mental illness too and cannot hold a real job, and that is why I roam the streets on a weekday… My friends do not know that I have schizophrenia. I keep it a secret. People might be able to tell my condition because of the people I am with (PAR co-researchers). But just because we could get labeled, it should not mean that we should be prevented from engaging our own community setting.

Many of our co-researchers agreed with the perspective that they cannot control what others assume about them, and that social isolation also brings about unwanted risks. To that end, suggestions were raised regarding compromises, such as attending field trips together on weekends where outdoor activities may raise less speculation and also combat the sense of loneliness when the clinic is closed, or only visiting places where they have felt safe in the past, such as the public library and Brooklyn Botanical Gardens. The co-researchers came to the

agreement that they would discuss the benefits and purpose of every location prior to deciding to travel in the community as a group, and to clearly outline how each trip fulfills the team's needs and goals with minimal risks. Tina, despite showing the most concern regarding identifiability as persons with mental illness diagnoses, thanked the PAR team for validating her concern and helping build confidence in the team's ability to compromise and problem-solve together.

Identifying wisdom from our personal journeys of recovery. As we embarked on uncovering different facets related to mental health and recovery, our co-researchers shared crucial elements that promoted treatment adherence and therapeutic rapport. One aspect is learning to attune to one's mood fluctuations, life events, and changes in perception. They reflected on the tendency to increasingly withdraw and isolate oneself the more fearful and confusing one's environment appeared.

Lai-Do's pearls of wisdom. Lai-Do talked about the development of voice-hearing likely stemming from ongoing disappointment from the stress and disability to finding gainful employment. As much as she observed the voices to be bizarre, she also felt that she could turn to them for comfort and courage to point out issues that she was afraid to verbalize. Lai-Do attributed her recovery to the opportunity to communicate her inner thoughts with her counselors. She emphasized that psychoeducation and strong therapeutic alliance with her counselors helped facilitate her compliance to treatment and understand the function of the voices. She felt that reality-checking and understanding the role of the voices helped her become more discerning of the voices she hears, as well as seeing the connection between her mood and the tones and content of the voices.

Ge-Li's pearls of wisdom. Ge-Li shared her perspective on the importance of having an attentive doctor (she believed that her doctor was her lover) who accompanied her and stayed by

her side when she did not feel well. Although some members appeared skeptical of Ge-Li's romantic experience, the team explored the deeper underlying feeling that people undergoing treatment perhaps wished to experience, such as feeling desirable, loved, valued, attended to, supported, and needing to trust that there are individuals (professional or not) that have their best interest.

Tina's pearls of wisdom. Tina described the impact of her religious beliefs. She explained how horrified she had felt from seeing people's faces turn into demons and being chased into hell. She recalled feeling extremely terrorized and distrustful towards her family. She reflected on discovering the link between her moods and her perceptions whereby the aberrant perceptions worsened as her anxiety heightened and her depression deepened. She described feeling more dependent on her religious faith as she experienced a loss of control over the adverse events that were occurring in her family life. However, she found that being connected to the day treatment program and gaining practical solutions to her issues allowed her to regain self-efficacy over her condition.

David's pearls of wisdom. David shared that his symptoms began around the time of his parents' divorce. He later moved to the U.S. with this father, with whom his relationship deteriorated further. He also described the family's ongoing stressors, including failure to find employment and conflictual family relationships that precipitated his hearing hostile and aggressive voices. He returned to China, where he reunited with his mother and began receiving psychiatric care. He believed that although mental illness is highly stigmatized in China, he had access to social and environmental support that he was restricted from in the U.S. Combined with psychiatric and mental health treatment, his condition stabilized and allowed him to realize

the need to maintain treatment and gain access to Chinese peers and treatment providers when he returned to the U.S.

Ah-Tung's pearls of wisdom. Ah-Tung described that he overcame his experiences with perceptual aberrations with the help of cognitive behavioral techniques and medications. He expressed that while medications helped dampen the frequency and volume of the voices, they caused sedation and were unhelpful with challenging and understanding the function of the false beliefs and voices. He felt that he made more meaningful recovery by learning to apply critical thinking to the delusional beliefs and problem-solving skills with the ongoing support of his counselors.

Bai-Hua's pearls of wisdom. Bai-Hua shared with the team that her feelings of persecution and betrayal stemmed from enduring financial strain, unemployment, and increasing disconnect she felt between her and her children's assimilation of Western societal norms and values. She saw that her isolation might have been mitigated with increased community outreach of psychological and social work services to poor, immigrant populations, to help her learn that she had a mental health while gaining support to combat the deleterious effects of poverty, acculturation issues, and psychological trauma.

Grace's pearls of wisdom. Grace shared about suffering from persecutory beliefs and social anxiety. She found consistent attendance to treatment groups to be the most effective component to her recovery. She learned through a process of desensitization where she consciously learned to apply social skills that promoted relationship-building. She found herself feeling rewarded by the positive social experiences, and she eventually learned to trust group settings and gained confidence by playing a supportive role for others.

Andy's pearls of wisdom. Andy, our youngest co-researcher, shared his experience of actively hearing voices. He found his family's acceptance of his psychiatric condition to play a central part in his treatment. In particular, his family's involvement helped him feel supported and focused on overcoming the hostile voices. Their willingness to engage in treatment, such as learning about the purpose, side effects and dosage of his medications allowed his condition to feel like a shared family experience.

Gathering Community Resources on Recovery.

In addition to forming good relationships with their treatment providers, our co-researchers weighed in on the benefits of applying self-help techniques to combat the emotions and interactions that diminish their self-esteem and confidence. Our co-researchers expressed a desire to learn more autonomous and empowering ways of seeking greater inner peace when challenging situations emerge. The team decided to embark on a project of gathering resources on mental health and self-help techniques that could promote positive self-efficacy in managing diverse social and environmental demands.

Gathering resources on the subject of self-help. Three of our co-researchers visited a local public library to collect resources on self-help and recovery. They reported finding the experience to be eye-opening. The librarians' patience and friendliness, as well as only finding two Chinese books on mental health and self-help surprised our co-researchers. The library visit debunked the presumed difficulty and obstacles involved in navigating an extensive public library. Their positive interactions with the librarians promoted a sense of safety and their ability to form significant relationships. Conversely, they were disappointed by the lack of self-help material on mental health issues that were available in Chinese. The perceived message from the scarce material was that self-help and psychology were taboo and unpopular subjects that are still

hardly researched or talked about in the community, an area that our co-researchers wanted to address.

Out of the two books checked-out from the library, the team decided to focus on the one on positive psychology. Although initially intimidated by the process of reading scholarly material, our co-researchers found it beneficial to face the challenge of studying the material in manageable chunks. Our co-researchers divided the chapters among each other, with the goal of summarizing the content to the team. Quotes and information that our co-researchers found relevant, inspiring, and useful were shared with the group and spurred conversations on how the knowledge could be applied to their personal circumstances. Our reflections were recorded on a poster as they were gathered from reading the literature.

Identifying the strengths and weaknesses of the application of positive psychology on the population. Our co-researchers felt particularly drawn to the value of recognizing the "five riches" of life: good health, reliable friends, harmony within the family, peaceful mood, and the opportunity to compete. Our co-researchers reflected on how the "five riches" have manifested in their lives. The co-researchers identified the following areas for which they were grateful for: symptom stability, having treatment providers that they could trust, having supportive family members, having good physical health, having the ability to keep the home clean and warm for family members, being literate in Chinese, being accepted to the PROS program, and joining the PAR team. At the same time, the exploration of positive psychology also brought a set of ambivalent reactions to our co-researchers. They found the concept to be diametric to cultural norms that Chinese would typically feel ashamed about, such as requiring government assistance and receiving psychiatric care. Furthermore, our co-researchers identified that within the Chinese culture, true happiness is experienced only when it is happiness shared. If

happiness is only experienced by the person pursuing it, without regard for their loved ones' feelings and how their emotions would impact others, then that person is considered selfish and irresponsible. Our co-researchers' history of mental illness has marked deep scars of trauma for them and their families. They perceived their past behavioral and psychological manifestations of the illness so damaging and irreparable that they experience difficulty forgiving themselves as victims of the disorders and the malfunctioning systems from which their conditions exacerbated. Therefore, despite many of our co-researchers having achieved stability and feeling grateful for the improvement on a shallow level, they feel deep shame and despair for causing sorrow and having disgraced their families with the ramifications of their illness.

We noticed there appeared to be increased ease and comfort with reading aloud the materials as the co-researchers offered personal examples to illustrate or challenge the information, and simply showed more curiosity in each other's life experiences. We reflected on the literature review initially being a daunting task that evolved into dynamic and fruitful conversations. The co-researchers found the use of readings to have a grounding effect on their stories while their narratives gave life to the reading material. Snapshots of the notes gathered during the literature review are attached in Appendices R and S.

Building on our knowledge base of recovery with a guest speaker, part 1. Our co-researchers concurrently gathered other types of resources on the subject of recovery information, such as watching YouTube videos and inviting guest speakers. One guest speaker was at the time, the Director of Rehabilitation Programs at New York City within the Department of Health and Mental Hygiene, who was herself diagnosed with bipolar disorder and a survivor of the psychiatric system.

A former deputy director of the Howie the Harp Peer Advocacy and Training Center, our guest speaker attended our PAR meeting on September 10, 2014 and shared her journey of recovering from bipolar disorder. She described her recovery as nonlinear, fraught with setbacks and relapses yet she gradually transitioned from being a patient to an advocate of peer support groups. She also strongly encouraged our PAR team members to develop their own peer support groups, and to consider joining well-established peer advocacy and training programs to facilitate their own recovery.

Our co-researchers expressed feeling a sense of validation and normalization from meeting our guest speaker. They felt the most significant lesson was to learn that mental illness existed across social class, educational, ethnic, and immigrant statuses. They also critically examined the difference in social identities. Specifically, they saw that our guest speaker's non-immigrant status, fluency in English, strong assimilation to mainstream Western culture, and graduate level education afforded her privileges and opportunities that our co-researchers believe were closed off to them. Simultaneously, they found this guest speaker's message to move beyond the confines of what is deemed achievable by the population to be uplifting and empowering, as it contradicted from the common message that schizophrenia is a severe and chronic disease. A snapshot of the notes gathered during the guest speaker's visit is attached in Appendix S.

Building on our knowledge base of recovery with a guest speaker, part 2. The team also invited the co-founder of The Icarus Project. Diagnosed with bipolar disorder, our guest speaker was a community activist who challenged the traditional concept of mental illness and taught alternative conceptions of wellness. In his workshop with the PAR team, he encouraged the team to think about questions such as: What brings us together? What is normal? What does

wellness mean to you? What do you do to stay "well"? Our guest speaker shared his voyage through the mental health system, making meaning out of his experience, channeling his voice and connecting with numerous survivors of the psychiatric system, and ultimately developing the grassroots movement of The Icarus Project. He encouraged the team to challenge the role of medication and to view it as a treatment for "sensitivity to the madness in the world." He further encouraged the team to engage in story-telling and one's position on recovery in the context of history, community, and society. The team was also introduced the technique of speaking from the various vantage points that our inner voices represented to gain a more in-depth understanding of all parts of us.

Examining diverse views on medication and recovery. Our guest speakers' visits sparked a deep examination of what medication adherence represented for our co-researchers. The team was encouraged to critique on the prevailing notion that medication was the royal road towards recovery. Our co-researchers' examination of the topic revealed an unwavering desire to overcome the trauma of mental illness for themselves and their families. In the wake of the disorienting effects of serious mental illness symptoms combined with the domino effect of multiple losses resulting from long-term treatment, medication adherence to our co-researchers was a pragmatic means to managing difficult emotions and preventing the re-emergence of symptoms. Culturally, long-term medication compliance represented a victorious aspect of treatment given its discrepancy from Chinese norms that medications are only ingested for short periods of time, with the expectation that the condition would be healed. For our co-researchers, medication compliance took a tremendous amount of strength and commitment to achieve as they adopted the Western concept that long-term psychiatric medication compliance represented control and responsibility over their condition, a position that had been positively reinforced by

Western treatment providers but contrasted from the Chinese cultural expectation that symptoms would eventually abate and medications be tapered off. If medication adherence was evidence of dedication to achieving wellness and offered family members solace because it complied with treatment authorities, then our co-researchers saw the need to persevere with long-term medication usage despite ambivalences towards the side effects and the conflicting cultural and institutional messages.

Examining the role of romance and intimacy in recovery. Our guest speakers also promoted our co-researchers' examination of the topic of romance and intimacy, an area that the team members believed has been neglected throughout their treatment and recovery. Divergent views were presented during the team discussions. Some co-researchers described their experience of the mental illness driving apart their relationship with a partner. Many of our co-researchers held the beliefs that only people with unattractive qualities would pursue a relationship with a person with mental illness; nobody would be attracted to someone with mental illness, and a person should end a relationship if their partner develops mental illness. Some of our male co-researchers expressed guilt for desiring intimate relationships despite believing that they will *lian lei* (harm and bring down) another person and their family with their mental illness and lack of employment. The team members saw their perceived illegitimacy to pursuing romance and intimacy to be reinforced through the lack of communication and encouragement on developing intimate relationships during their treatment. Instead, symptom stability is conveyed as the primary treatment priority, which indicated to the team members of the implicit biases that have historically existed on professional and institutional levels toward people with mental illness and their capacity to have intimate relationships.

Expanding Our Knowledge on The Role of Employment and Other Essential Factors to Recovery Through Survey Development

The team decided to construct a survey to build upon knowledge that is informed by the population's experience on the essential factors to recovery. We saw this to be a practical approach to consolidating our understanding of survey development and expanding our wisdom on recovery while collecting information that could be advantageous to improving vocational access at PROS. Based on our co-researchers' deep concern regarding treatment needs and workforce considerations, feasible work hours emerged as an important question that our co-researchers wanted to explore. Child-care and household responsibilities were identified as primary reasons for the female co-researchers to prefer part-time employment. Managing treatment at the day program and clinic appointments were identified by both male and female co-researchers as essential reasons to preferring part-time employment. Conversely, our co-researchers wondered how other PROS participants delegated their hours of the week. As such, the team created a question that offered various choice options on the activities that participants could be engaged in, and how might those activities impact their preference for part-time employment. Next, our co-researchers wanted to know the obstacles to successful employment that PROS participants would like support for. In addition to employment, our co-researchers were curious to find out about relationships that were found most crucial to the PROS respondents' recovery. Lastly, our co-researchers wanted to find out the area of concern that PROS participants would most like the PAR team to further investigate. A snapshot of the survey development is attached in Appendix R, and a copy of the survey developed by the PAR team is attached in Appendix T.

Developing hypotheses. The team engaged in generating hypotheses for the survey. The team members were challenged by the process of aggregating the knowledge gathered from their personal experiences and literature review to derive hypothesized outcomes. Nevertheless, our discussion on hypotheses helped unravel personal biases and stereotypes toward specific demographic groups. For example, we observed that our male team members were more inclined to suggest that female co-researchers would prefer activities that were less oriented to vocational development while predicting that male respondents would endorse the desire to work more hours in the week compared to female respondents. The observations propelled us to uncover the variables that were believed to moderate or mediate the effects of one's preference for vocational opportunities. For example, the team conjectured that female respondents would endorse wanting to work similar hours as men if they did not uphold the need or obligation to participate in activities that took them away from their vocation, such as caregiving responsibilities in the home. The team also hypothesized that more than 80% of both male and female respondents would want to seek employment, the majority of the respondents would fully complete the questionnaire given the participant and agency's emphasis on vocational rehabilitation, and all respondents would endorse the need to engage in psychiatric care for activities outside of work due to the prevalence of symptom exacerbation when medical treatments are halted.

Preparation for survey dissemination. Each team member joined one of two teams in finalizing the survey and preparing for the program-wide meeting.

One team designed a speech that was aimed at communicating the team's desire to increase understanding of the PROS participants' needs and concerns surrounding the subject of employment and recovery, and to provide recommendations that are based on the collected data to treatment practitioners on how best to support the participants. The speech went through

numerous revisions as the co-researchers painstakingly edited and rehearsed the material. This process also elucidated anxious and nervous feelings that many of our co-researchers shared as this was their first speaking engagement in front of a large audience that was comprised of PROS participants and staff. This period was also marked by the co-researchers' perseverance and commitment to helping each other overcome the emotional barriers through feedback, encouragement, and continuous practice.

The second team was responsible for typing up the survey. This team was comprised of co-researchers who were more familiar with operating a computer and typing Chinese. The two teams often reconvened to practice the speech as well as the mock survey. In taking the survey together, the team observed areas that required editing to meet increased sensitivity. For example, we contemplated the feelings evoked by the demographic items. Our co-researchers were sensitive to their past experience of being disqualified or deemed ineligible for certain opportunities when they revealed their age or education level. Keeping in mind the goal of creating a survey that promoted cultural sensitivity, safety, and inclusivity, the co-researchers decided to provide an age range for respondents to check off to lower the risk of causing discomfort. We also went through numerous revisions to edit questions that were found to be too triggering, convoluted, or complicated to answer.

Preparation for survey dissemination – the team's vision. In anticipation of disseminating the survey, our co-researchers identified aspects to the recruitment that were important to them: having all PAR co-researchers be involved in explaining to the participants the purpose, being available for questions throughout the survey collection, and preventing participants from experiencing coercion. To achieve the goals mentioned above, the team

decided that its members would be the one to directly disseminate the survey versus having the counselors make the announcement or handing them out.

The team sought approval from the PROS director to host a program-wide meeting and for survey dissemination. She was invited to a PAR meeting to discuss the request and flesh out the details of the project implementation. The team reviewed the discussion points in preparation for the meeting with the director, such as the purpose of the research, concerns regarding power differentials that would be present at the community meeting, who would hold ownership over the project, and ways in which staff could support the team's mission. Time and location for the program-wide survey dissemination were also approved.

The team assessed the meeting with the PROS director to have gone very well. Our co-researchers proclaimed a sense of pride regarding their first experience of hosting a meeting and "having a seat at the table." It was also an important milestone for the team because of the leadership role the co-researchers took in expressing ownership and control over the team's project. As Bai Hua stated, "I was nervous that the director would reject our requests because I've never seen participants make demands in the way that we did. I am happy that she values what we are doing and wants us to succeed."

We were later informed that the PROS director was unavailable at the time of the survey dissemination but had created a video to show her support. Our co-researchers wondered if playing the video of the director could be a strategic way of demonstrating the legitimacy of their work, but wanted to ensure that it did not indirectly coerce participation. Therefore, our co-researchers decided to include in their speech that any participation would be entirely voluntary and that declining to participate in the survey would have no impact whatsoever on participants' treatment programs at CMHC.

Implementation of program-wide survey dissemination. On the day of the survey dissemination, we played the PROS director's video followed by the PAR team's introductory speech and distribution of the survey. All of our co-researchers stayed for the full half hour of the meeting to avail themselves for questions or comments from the participants and counselors. PROS staff were also present to support the endeavor by following the instructions set by the PAR co-researchers. The co-researchers shared that they felt pleased to see PROS participants listening to their message so intently, asking clarifying questions on the survey, and staying beyond the expected duration of the program schedule in order to fully complete the questionnaire.

Our co-researchers expressed a sense of pride and exhilaration from developing and collecting the survey. They felt anxious when they first delivered the speech but were filled with a sense of empowerment once they observed their project being taken seriously by both staff and participants. They described feeling respected and valued for what they were bringing to the program. Simultaneously, they described feeling more responsible for their environment and how they were affecting their peers and finding themselves taking extra care in how they were supporting each other, the staff members, and other PROS participants.

Examining the Results of the CMHC Survey

Data analysis was focused on exploring the following hypotheses: 1) male respondents were expected to endorse a desire to work more hours than female respondents; 2) more female respondents were expected to participate in non-work-related activities than men; and 3) more than 80% of both male and female respondents were expected to endorse the desire to seek employment; 4) the majority of respondents would fully complete the survey, and 5) all respondents would endorse the need to engage in psychiatric care for activities outside of work

due to the prevalence of symptom exacerbation when medical treatments are halted. A snapshot of the data calculation generated from the team meeting is attached in Appendix U.

Demographics. The survey was completed by 29 PROS participants (20 men, nine women). 7% fell in the 18-25 age range; 14% fell in the 26-35 age range; 31% of the participants fell in the 36-45 age range; 31% fell in the 46-55 age range, and 21% fell in the 56-65 age range. In terms of education level, 10% attained a primary level of education; 28% attained middle school education; 34% achieved a high school degree; 24% achieved a college degree, and 3% achieved some form of technical training.

Preferred hours of employment. With regard to question 1 ("How many hours of employment do you find suitable for you?"), among 20 male respondents, 20% wanted to work 28 hours or more a week; 5% wanted to work 24-27 hours a week; 10% wanted to work 20-23 hours a week; 10% wanted to work 16-19 hours a week; 20% wanted to work 12-15 hours a week; 15% wanted to work 14 hours or less a week; and 20% preferred unemployment. Among 9 female respondents, no respondent endorsed wanting to work 28 hours or more a week; 11% wanted to work 24-27 hours a week; 11% wanted to work 20-23 hours a week; 11% wanted to work 16-19 hours a week; 44% wanted to work 12-15 hours a week; 11% wanted to work 14 hours or less a week; and 22% preferred unemployment.

Managing responsibilities outside of employment. Regarding question 2 ("What type of activities are you responsible for outside of employment?"), the order from the most endorsed item to the least endorsed item ranked as follows: 1) managing psychiatric treatment responsibilities (79%); 2) visits to a psychiatrist (69%); 3) rest (66%); 4) social engagements (40%); 5) medical treatment (17%); and 6) a tie between "entertainment" and "family" (14%).

Obstacles to successful employment that PROS participants would like assistance with. Based on the responses to question 3 ("Which of the following are obstacles to successful employment that you would like to receive more support?"), the order from the most endorsed item to the least endorsed item ranked as follows: feeling nervous/ anxious in novel surroundings (62%); fear of relapse from overwhelming nervousness/ anxiety (55%); mood symptoms (40%); a tie between traffic/commute issues and behavioral problems (31%); fatigue and drowsiness (28%); decreased memory and cognitive ability (21%); delusional beliefs such as paranoid thoughts /positive symptoms such as hearing voices (17%); and language barrier (10%).

Relationships that play the most crucial role in your recovery. According to the responses for question 4 ("Which of the following relationships play the most crucial role to your recovery?"), the following list emerged ranging from the most endorsed item to the least endorsed item: family relationships (83%); friendships (55%); compassionate relationships (40%); and romantic relationships (21%).

Areas that PROS respondents believe they could benefit from further examination from the PAR team. Based on the responses to question 5 ("Out of the four topics above, which topic do you believe you could benefit from the PAR team's further research?"), the responses ranging from the most endorsed item to the least endorsed item were: relationships (48%); hours of employment (38%); obstacles to successful employment (31%); and responsibilities/ activities outside of employment duties (14%).

Deconstructing the Social and Cultural Constructs of the Findings

Gender. The finding that there were far more male participants than female participants at the agency matched with our co-researchers' observations and expectations. The team postulated that fewer Chinese women received treatment for several possible reasons, including

holding more responsibilities in the home which prevented them from receiving formal mental health support; having support systems that mitigated the impact of mental illness symptoms; or were less likely to be have been diagnosed with a serious psychiatric disorder compared to men.

Age. We found that most respondents fell within the 36 to 55-year-old age range. Consistent with their own lived experiences, our co-researchers theorized that adults in this age range are challenged by unique social and family obligations. The co-researchers explained that middle-aged Chinese experience greater pressure for stability and economic acquisition due to one's obligation to support both the elders and children in the family. They further explained that middle-aged Chinese male immigrants are often the initial members to participate in the migration journey to establish networks and stability overseas before sponsoring spouses and family members to join them in the host country. Our co-researchers described that middle-aged Chinese male immigrants are therefore placed under immense pressure to repay the debts borrowed for the immigration and to save money to send back home while working below minimum wage. These financial and social pressures occur in addition to the traumas of illegal immigration, acculturation stress, poor living conditions, and long work hours.

Education. In terms of education status, the co-researchers were surprised to find that most respondents held an education level beyond middle school. Seven respondents had acquired a college degree (24%) and ten respondents (34%) held a senior high school degree. Our co-researchers were struck by the sudden awareness of the unconscious bias and assumption that people who suffered from mental illness symptoms were lower-achieving in terms of education level. This finding validated many of our PAR members' experiences; PROS participants were also people with mental illnesses whose talents and potentials were unrealized due to psychiatric symptoms and oppressive circumstances. This finding appeared to have a healing effect on our

co-researchers' self-stigma and social stigma. For example, Ming-Zuo noted, "Anybody can develop mental illness. We aren't just sick people. We should be recognized as educated people and be respected for our achievements." They further challenged the tendency to underestimate the competency and capacity of their peers and instead questioned the environments that perpetuated the ideology of personal deficits and psychopathy rather than the celebration of each other's strengths.

Preferred hours of employment. Concordant with the hypothesis that male respondents would prefer more hours at a work place than female respondents, the results demonstrated that 20% of the male participants preferred i) 28 hours or more of employment per week and ii) 12-15 hours of employment. No female participant endorsed the 28 hours or more preference. The co-researchers found this finding to be consistent with the tradition that men are expected to carry a stronger occupational identity and more financial responsibility for the family. Conversely, they are less expected to be involved in other realms, such as caretaking responsibilities in the home, areas that women are likely more expected to fulfill and therefore have less time and resources to designate on employment opportunities. The majority (44%) of female respondents preferred 12-15 hours of employment per week. The team identified that treatment or day program responsibilities might logistically hinder both male and female respondents from preferring and achieving more work hours despite vocational goals being a primary goal at PROS and other treatment facilities.

Managing responsibilities outside of employment: Treatment and non-treatment-related responsibilities. The finding that the three most endorsed responsibilities -- managing psychiatric treatment responsibilities; visits to a psychiatrist; and rest -- were related to psychiatric treatment correlated with our co-researchers' experience of traversing the mental

health system, which was to prioritize clinical treatments for symptom management above all else. The team identified that the fundamental rule internalized by the co-researchers and their families is that recovery can only be gained primarily through clinical and medical channels. Factors that could enhance the quality of life, such as romance and employment, are understood to be of less importance. This finding strengthened the awareness of treatment being clinically and medically-driven rather than health, wellness, and strength-based community resources, thus perpetuating a vicious cycle whereby participants struggle to break free from institutional dependence to achieve personal control and ownership over their recovery.

Entertainment and family. "Entertainment" and "family" were the least endorsed items that the respondents engaged in. Our co-researchers resonated with the findings. They described an isolated lifestyle that was devoid of hobbies and entertainment beyond treatment obligations. They described typically traveling between their homes, CMHC, medical clinics, and the grocery store during the day and hardly going out at night with friends or families. They also described their family members being occupied with work and responsibilities within their own nuclear families, which made it difficult for the co-researchers to spend time with them.

Barriers to employment: "Nervousness and anxiety around novel situations and environments." The team's exploration of the most endorsed employment barrier -- "nervousness and anxiety around novel situations and environments" -- revealed that our co-researchers' interactions with their social environments had narrowed significantly since the onset of their mental illness symptoms. They found themselves feeling distrustful of how they might react or become triggered outside of a treatment facility. The protective connection with a familiar treatment facility combined with a history of experiencing states of confusion prior to a full-fledged episode had resulted in co-researchers' fears of the physiological and emotional

reactions that could emerge from being in unfamiliar territory. Our co-researchers have seen a dip in their self-confidence despite learning new methods of coping. This awareness is causing them to begin calling into question traditional treatment models where psychiatric survivors are inadvertently infantilized in their capacities to cope with confusing perceptions and dependent upon a treatment facility.

The co-researchers further questioned the extent to which the severity of their mental illness had been impacted by cultural and systemic oppressions. Specifically, the team identified prolonged feelings of anxiety and discomfort stemming from chronic social, economic, political, and vocational exclusion due to their identities as Chinese immigrants, psychiatric patients, and poor working class people. For example, they noted the lack of access for monolingual Chinese with psychiatric conditions to participate in peer support programs such as Howie The Harp, or to become certified and paid peer specialists. Thus, the team identified immigrants with social statuses like theirs being relegated to more confined and medically-driven treatment rather than more holistic and strength-based services.

Mood symptoms. Our co-researchers resonated strongly with the respondents' endorsement of mood symptoms being the third most endorsed barrier to employment. Our co-researchers described pervasive pessimism and hopelessness surrounding their circumstances as they had found themselves falling short of expectations in terms of achieving the goals on their treatment contract despite their focus on treatment compliance. The team detected complex internal conflicts wherein our co-researchers had found their moods controlled by medications ("[My mood] always stays on a 6") accompanied by an omnipresent sense of grief that is suppressed from full expression. They wished to have the medications tapered off, yet were afraid of what might emerge if they were not under the influence of medications.

Traffic/commuting issues. The co-researchers found the concept of traffic and commuting issues to coincide with other problems associated with leading an isolated lifestyle, where opportunities for social, economic, and cultural mobility and exchange are limited. The co-researchers voiced concerns about being away from CMHC or their homes with their limited English verbal and reading abilities. This apprehension had impeded the co-researchers from casting a wider net in searching for employment opportunities.

Behavioral issues. Behavioral concerns were the fourth most endorsed item, a tie with traffic and commuting issues. Our co-researchers had survived behavioral traumas triggered by unusual perceptions. Given their limited exposure to novel daily experiences outside of CMHC, our co-researchers were concerned about unexpected triggers of behavioral abnormalities as the result of venturing into unfamiliar environmental interactions. Simultaneously, our co-researchers expressed a degree of command over their behaviors in structured treatment environments, and longed for opportunities to demonstrate mastery in a more generalized manner as well as to be capable of more spontaneity in their social engagements.

Fatigue and drowsiness. Fatigue and drowsiness were the fifth most endorsed obstacle to employment. Some co-researchers found this result to be consistent with their own experience as several found themselves to be severely impacted by this issue as a side effect of their medications. The team discussed how different types of medications and their dosages impacted individuals differently. This finding, however, brought awareness to the co-researchers who suffered from this problem that a well-balanced energy level could be achieved in consultation with their psychiatrist. This motivated them to consult their doctors to work towards achieving more optimal energy levels.

Decreased memory and cognitive ability. Cognitive and memory impairment was found to be the sixth most endorsed obstacle to employment. The co-researchers were not surprised by this finding, although this it represented a contrast with the literature on the relationship between schizophrenia and cognitive impairment. The team identified that as participants who have had an extensive history at a day program, they are well-versed and cognizant of the day-to-day operations at CMHC. However, with regard to learning new information or technology, they found themselves lagging behind the general public. Relatedly, our co-researchers had found that CMHC was unable to offer more access to computers nor the learning tools to effectively operate one. Similarly, it has been difficult to find experts in vocational training or the English language to meet the needs of the participants. The team recognized that the poverty status of their population, as well as the location and available funds for CMHC, are significant factors in their limited experience with the cultural and technological exchange.

Delusional beliefs and voice-hearing. The presence of delusional beliefs and voice-hearing was found to be the second least concerning obstacle to employment. Our co-researchers' assessment of their own conditions revealed that some of them no longer suffered from active voice-hearing, while some did but had found effective coping methods to continue on with their daily living. Some co-researchers endorsed continuously feeling surveilled and judged, perceptions that had been clinically labeled as paranoia or persecutory delusions. The team discussed how this might be in fact a realistic and accurate assessment of their environment, as they were continuously watched and analyzed by treatment providers whose assessments had far-reaching consequences in their lives. Our co-researchers identified a strong paternalistic element to the way treatment has been developed for people with psychiatric labels. They voiced a need

to alter the modality such that power was shared more evenly and decisions were made transparently. This shift would allow participants to feel more empowered and to be in the forefront of making decisions for optimal recovery.

Language barriers. The issue that language barrier was the least endorsed obstacle to successful employment came as a surprise to the team. Most PROS participants were monolingual Chinese. Based on the finding, the team identified that the respondents might have primarily comprehended employment as occurring within Chinese-speaking communities and therefore perceived language as a low level of concern.

Relationships that participants find pertinent to their recovery. The team found that family relationships were perceived as the most crucial relationship to their respondents' recovery, a result that was consistent with their own experiences. The co-researchers found that despite the depth of distress and shame that their mental health labels have created for them and their families, Chinese culture is still inherently collectivistic, and persons from the same family are obligated to maintain interpersonal harmony and *guanxi* (interpersonal connections) out of a sense of duty and responsibility owed to the family and community. Romantic or intimate relationships, on the other hand, were ranked last in terms of contribution to recovery. For our co-researchers, these forms of relationships were severely lacking and they found this subject to be largely sidelined from recovery-oriented conversations at the treatment facility.

The benefits of more research on relationships. The team found that relationships seemed to represent a topic that respondents wanted to learn more about, which demonstrated the significance of healthy and prosperous relationships to mental health recovery. Contrary to the misperception that people diagnosed with serious mental illness wish to withdraw and be isolated, our results indicated that beneath withdrawal or seemingly negative symptoms, this

population contemplates bettering their relationships and expanding their interpersonal connections. The team speculated that the collectivistic mentality within Chinese culture might accentuate this population's awareness of their wellness and life satisfaction being closely connected to another person.

Organizational Changes Within the Agency and Their Impact on the PAR Team

As the team envisioned ways of sharing their findings, we also wanted to address Tao's resignation from CMHC and its implications on the team. The team was struck with uncertainty on the future direction of PAR as the co-researchers mourned the loss of a deeply cherished PROS counselor as well as Joyce's upcoming completion of her CMHC externship in May 2015. Tao's resignation was the third resignation over the span of two months at CMHC PROS and prompted the team to examine the influencing factors and ramifications of PROS counselors' resignations. The co-researchers identified the role of counselors as paramount to their recovery as they journeyed through the various stages of treatment, from facilitating their initial entry into the mental health system to serving as a bridge to supportive services in the community. The counselors had, as our co-researchers described, become pillars of support that had helped them and their families through turbulent and traumatic relapses.

Identifying the impact of PAR on our wellbeing and hopes for the group. The string of resignations had caused a ripple effect across the agency beyond the PAR team. The issue of staff shortage and the two co-facilitators eventual departure from the agency left the PAR program vulnerable to cancellation after May 2015. The co-researchers expressed a desire to continue PAR but worried that their wishes would not be supported as treatment programming had typically been decided by management. To fortify their contention that PAR was an essential component of their recovery, the team decided to discuss their concerns with the PROS director

with a focus on the following key points: the need to continue the PAR program following Tao and Joyce's departure, the need to find a new co-facilitator with Chinese proficiency, and having the co-facilitator immediately begin attending the PAR meetings to learn and observe the existing culture and processes of the team. Our co-researchers saw this as a rare opportunity for them to champion meaningful programming for themselves and the agency. In addition to preparing material for the meeting with the PROS director regarding the PAR team at CMHC, the team also prepared for Tao's farewell. From organizing the date, time, location, food, and card, our co-researchers were involved in every aspect of planning both the program-wide party and the program meeting -- a first for our co-researchers.

The decision to invite a new co-facilitator. The co-researchers were particularly interested in having graduate students from the Counseling Psychology Program at Teachers College (TC), Columbia University who could speak Mandarin or Cantonese to participate in the co-facilitation. This decision was primarily based on the success that the co-researchers felt had been garnered from the partnership between a PROS counselor and a TC graduate student throughout the PAR team's implementation at the agency.

Advocating for increases in communication and transparency within the organization. The PROS director attended our team meeting on April 3rd, 2015 to discuss decisions on the PAR team. The co-researchers highlighted reasons for PAR to continue at CMHC PROS and explained how they would like the team to continue. Grace described her observation of the effect of PAR on the team members as a whole:

> We achieved more together in this team. We did research, a survey, community meetings, played games, went to borrow books together in the library. We were

> stronger because we learned a lot about each other and solved problems by sharing ideas. We didn't leave each other behind or let each other become isolated.

Tina described a similar impact of the PAR team on her individual well-being:

> I can trust this group to help me advocate for my needs. I believe that I can achieve what I need with the support and safety of this group. This group is very different. It has encouraged me to fight for what I believe in. We learned more about ourselves and each other when we created the survey and got answers directly.

Ah-Tung explained the effect of PAR on his recovery:

> We got to know more about the outside world, unlike other groups, where I thought they always reminded me of my disorder. This group opened my eyes. I became braver and more relaxed. It's what I needed in my recovery. I was afraid in the beginning. People usually think that being discharged from a hospital meant that the disorder was cured, but that is not the case with our illness. The journey afterwards can last a long time and make you feel very helpless and alone…[PAR] opened my eyes and made me realize that my disorder is just one part of me and that I was neither helpless nor alone. There is more to me than this disorder. PAR helped me realize that I did not need to be passive about what made me angry, confused, or upset.

Our co-researchers also described the benefits of recruiting an intern or counselor from the PAR research team at TC and referenced the success they had witnessed from a co-facilitation with a CMHC staff. The team's initiation of this meeting also promoted a conversation on the hiring process at CMHC and PROS. The director described the process of

involving the review of student applications, interviews, and a decision-making phase that included assessing the fit between an applicant's qualifications, training needs, and the agency's missions. Learning about the protective gatekeeping system at the agency for the first time was a reassuring experience for our co-researchers. They expressed feeling valued as they got to work with qualified professionals and students despite their marginalized statuses. The director agreed to the necessity of recruiting a new co-facilitator as soon as possible. She further expressed recognition of the value that PAR has represented for its team members in balancing power and promoting a more democratic process at the agency. In particular, the co-researchers' direct involvement and pro-activeness with examining critical components to their recovery, being involved in program planning, and advocating for improved communication and transparency between staff and participants. I (Joyce) was tasked with announcing the PAR team's recruitment of a new co-facilitator. This message was relayed to the research team at TC, and two Chinese-speaking students indicated their interest in applying for the position.

During this period, Chen, a graduate of the Master of Education in Counseling Psychology program and a counselor at CMHC, expressed her interest in co-facilitating the PAR team and our co-researchers were pleased to have her onboard as a potential co-facilitator. Two of our co-researchers had had Chen as their individual counselor and some had attended Chen's groups. They found Chen to be a trusted team facilitator based on previous contact as well as her credentials and welcomed her to be a co-facilitator of the PAR team.

Preparing for the possible outcomes for the PAR team. As CMHC PROS underwent program restructuring in response to staff shortage, the team wanted to prepare for possible outcomes for the PAR team after May 2015. PROS management communicated to me their cautiousness about continuing the team without staff who have expertise in the theory and

practice of PAR. To that point, it was explained to the director that the PAR co-researchers were as responsible for overseeing the direction of the team and acting on its behalf as I was. I offered to provide consultation as necessary, as did the research team at TC. The director also invited the team to develop a curriculum outline to facilitate continuity for potential new staff or participants that join the team down the road. The team felt some apprehension towards creating a curriculum as programs were traditionally designed by "professionals". However, we also recognized the rare opportunity for PROS participants to be directly involved in program development.

Identifying key goals and objects for the future direction of the PAR team. Our co-researchers identified key goals and objectives that they considered to be essential to the future directions of the PAR team. Specifically, they identified the importance of incorporating more outdoor activities with the purpose of promoting awareness of the rapid changes occurring within the community, enhancing one's capacity to manage novel and diverse situations, and shifting the treatment model away from psychoeducation and symptom management within the confined spaces of a treatment facility to increasing direct contact with people, information, and resources in the community. The co-researchers also valued the increased transparency that had facilitated their awareness of the operations within the agency, as exemplified by the PROS director's availability to the team and the ongoing meetings that have occurred with her to address agency and team concerns. The team wished to expand clear, open, and transparent dialogue across all levels of management and participants, and saw PAR be a paramount platform in achieving such goals.

Examining the impact of changes in staff. Our co-researchers identified growing changes in their treatment environment that they have found tricky to navigate. One concern was the struggle to develop a rapport with newly hired staff. Specifically, they observed that the new

counselors were less inclined to help with interpreting various notifications that they received via letters written in English. This concerned our co-researchers, as they worried about their Social Security, which is typically communicated through the mail, being at stake. The new counselors' position toward translation contrasted starkly from the participants' previous counselors. PROS participants found themselves feeling dissatisfied with the reasons and solutions provided by PROS counselors on addressing this concern. For example, PROS participants had been directed instead to no-fee translation services at a community center in Chinatown. Our co-researchers found this suggestion to be unhelpful as they attended treatment at CMHC most days of the week, and the translations service was unavailable on weekends. Furthermore, they required additional training and information to help them navigate the paths and procedures to acquiring the translation services, which had not been made available.

During PAR meetings, our co-researchers described the lack of response from their providers regarding their request for assistance with meeting these new challenges. They wanted to request an agency meeting in which concerns, details, and ideas could be openly discussed. Calling for a meeting sparked encouragement and hope for reaching a resolution but also trepidation around consequences for confronting staff. Directly calling for the attention of the staff was a highly unusual position for our co-researchers and PROS participants, and our co-researchers worried that there would be perceived hostility that might jeopardize the relationship between staff and participants.

Taking actions to ensure that our voices are represented in the community meeting. Staff was eventually made aware of the growing discontent among the participants, and called for a “tea meeting” where all members of the program could gather and openly discuss their concerns while tea was being served. Our co-researchers decided to use the PAR team meetings

to help with formulating and articulating questions and suggestions for the tea ceremony, and overcoming the anxieties and fears associated with speaking up about deeply personal issues with the staff in a large group setting. This process was found helpful by co-researchers in terms of narrowing areas of concerns while adjusting to the anxieties that emerged from practicing.

The PAR team met the week after the tea meeting to debrief and process reactions that had emerged. Our co-researchers expressed feeling defeated and disappointed by the tea meeting. They felt frustrated by the staff's answers regarding NY State requirements that the agency could not provide direct interpretation services but, as a mental health and rehabilitative agency, could facilitate the participants' objective to achieve such goals in the community. The co-researchers understood the agency's limitations but recognized that agency expectations were not realistically adjusted to the needs of the population.

Our co-researchers shared the observation that nobody actually drank the tea during the meeting. Our co-researchers explained that tea drinking symbolized congeniality and harmony. They reflected on the tense dynamics that had been present in the room, and worried that they had displayed hostility by not drinking the tea, although they found the tea-sipping behavior to be incongruous to the tension and frustration felt during the discussions. As Bai-Hua described,

> I left feeling really disappointed. I went in hopeful that something could be done. [The staff] kept giving us the same answers. I felt frustrated and dissatisfied by their answers. It is as though [the staff] don't hear our needs and we can only go by whatever they say. They kept giving us the same answers over and over. I did not like how the meeting was going so I did not have any tea before I left… I think I would have drank the tea if I felt relaxed and happy in the meeting. I noticed that nobody else had any tea either.

Our co-researchers described feeling responsible for the unfavorable outcome and struggled with self-blame for their perceived lack of skills to effect change. As Grace stated, 'I tried to speak up for the team and express what we talked about in the group. I think [the staff] was trying their best to help us reach a compromise… I was nervous in front of a large group, so I did not express our ideas as well as I had wanted. Perhaps [the staff] did not see my point very well.'

The team contended with internalized shame and responsibility for the oppression, powerlessness, low self-worth that marginalized groups are often influenced to feel. Rather than conceding to the oppressive circumstances, the team decided to use our awareness of hierarchical influences to undo the power imbalance by coming up with actions that we believed could influence meaningful change.

Shifting our role from being recipients with needs to being empowered change agents. As the co-researchers considered the community meetings, they identified the need for more accountability regarding the decisions and timelines that emerge from the meeting. The team decided to record their perspectives on the situation and what needed to be done and then deliver their suggestions to the PROS management through a letter. The team saw that this plan would alleviate the pressures of direct confrontation, present a record for the director and the staff to refer to, and offer staff the time and flexibility to consider different opinions.

Implementing a culturally-sensitive approach to advocacy. The team began drafting a letter of request for help with translating essential documents due to the co-researchers' language barrier. The letter raised the point that English-language notification letters caused significant distress when the co-researchers were unable to seek the necessary resources to decipher the message and were limited thereby in their ability to ensure their emotional and physical well-being. The letter explained that receiving Social Security constituted a large part of their well-

being. Given the language abilities of the staff, the team explained that the opportunity to review the content of notification letters with a counselor substantially helped with managing emotional distress and also facilitated their recovery via a pragmatic intervention.

The letter underwent numerous revisions as the team considered various angles by which to approach the issue and the implications of the messages. We were careful to select words that promoted collaboration and avoided conflict or antagonism. This exercise uncovered the social pressures and dynamics felt from the hierarchical nature of the co-researchers' positions versus the staff's positions. Specifically, our co-researchers felt vulnerable as the result of their marginalized identities, and consequently felt guilt and fear for challenging rules that were not working for them. Simultaneously, processing and publicly naming the program culture deepened the team's awareness of the various social forces and perspectives that were operating within the agency. For example, it clarified for the co-researchers how the counselors have been limited in their professional autonomy and marginalized by budget cuts and large caseloads.

These increasingly complete perspectives allowed the team to more carefully choose the tone of the messages that the team aimed to convey. The co-researchers determined this to be a timely opportunity to commend the staff for their contributions to their recovery. The co-researchers first identified strengths displayed by staff at the beginning of the letter and later called for collaboration to address the shared problems (i.e., scarcity of time for employees to meet each participant's recovery needs).

Our co-researchers provided recommendations to assist with the challenges faced by the agency's staff while noting participants' needs regarding translation services and also calling for more autonomy in their overall treatment. The recommendations included creating a new group focused on teaching participants the skills needed to decipher important letter notifications

related to Social Security or other benefits, learning to complete application forms, and disseminating materials that could bridge the participants' access to additional resources in the community. This new group was intended to help with the shortage of staff since one facilitator could offer a group for 10-15 participants to help with interpretation and skills training with the goal of increasing the participants' overall autonomy and skillset. After several more revisions and discussion on how best to present the letter, the letter was typed up, and signatures were collected among PROS participants before its ultimate submission to the PROS director. A snapshot of the draft and final versions of the letter are enclosed in Appendices V and W.

Termination. The team organized a farewell party for me on my final week of co-facilitation. We were greeted by the news that CMHC PROS would continue to offer PAR in its programming. We processed the team's reactions to my termination and the paths that they were to journey without me, such as methods of sharing the survey results within CMHC and research topics to revisit. The co-researchers volunteered personal and collective success stories that have occurred for them as a result of participating in PAR. Areas of growth and activities that had been facilitative of their self- and group-discovery were also reflected upon to further improve the PAR process at CMHC.

Following my departure from the team, I was informed by Chen that the PROS program had accepted our co-researchers' suggestion to create a new group that would address Social Security and translation issues. Our PAR co-researchers were also invited to be consultants to the new group's curriculum development. I served as a consultant to Chen's facilitation of the PAR group, which was continuing to operate as of March 2017.

Summary

The foregoing narrative documented a PAR team project that began with conceptualizing PAR as collaborative programming that focuses on multicultural awareness, social justice advocacy, and a recovery approach that aims at examining and changing the issues impacting the Chinese participants of the CMHC day treatment program. A team consisting of two staff co-researchers and 10 PROS co-researchers engaged in critical inquiry of the social, political, and cultural influences that have prevailed within team members' experiences of living with serious mental illness diagnoses. Exploration of the oppressive and discriminatory circumstances in the psychiatric system endured by poor Chinese immigrant participants set the stage for potential areas of research and social change. The team members encountered an array of issues that were relevant to their mental well-being -- issues related to recovery, trauma from serious mental illness symptoms and psychiatric treatment, marginalization and stressful acculturation processes, community discrimination, power differentials, and exclusion from participating in critical cultural milestones. Information gathering regarding the subjects above was facilitated through open-ended group discussions, and critical dialogues of materials gathered in the community (i.e., through field trips to local cafés and library, inviting expert guest speakers, and practicing various research methods).

The co-researchers identified the issue of employment among Chinese immigrants with serious mental illness diagnoses as their chosen research topic through consensus-based decision-making. The co-researchers created a survey to understand the psychosocial barriers to achieving employment and methods to improving vocational access for the population. All team members assisted with developing the survey questions and choice options. They contributed differently to the survey refinement and distribution differently, in that some members were responsible for typing the survey, and others were responsible for developing and reciting a

script for the survey recruitment. The egalitarian goals of PAR were nurtured through meetings with PROS management on how staff could best support the co-researchers' vision of the research process. The team's collective efforts achieved a successful outcome with the survey recruitment. The PAR co-researchers found themselves experiencing new levels of autonomy and empowerment and realizing their power to accomplish their project endeavors and mobilize agency staff to achieve a democratic research collaboration.

The PAR team engaged in several stages of analysis of the survey outcome. We first divided into small teams to populate the data followed by extensive group discussions to describe observations and findings. Some findings converged with our co-researchers' personal experiences, which provided a deep sense of validation for our co-researchers' often silenced stories. Some observations were more unexpected, which brought attention to the diverse experiences encountered by Chinese PROS participants. The reflexive, cyclical praxis of asking questions and interpreting the data based on our social location and cultural identities helped the PAR team make new observations, challenge each other, speak out against the invisible dilemmas that affected their everyday lives, assemble pieces of information and co-create new knowledge and solutions. Furthermore, the analytic process offered an invaluable opportunity for the team to identify weaknesses in our research process and ways of improving future methods.

Following the team’s research activities, the PAR team addressed several recent and longstanding organizational challenges encountered by PROS participants and staff. One issue concerned continuing PAR at CMHC. Another issue involved the hiring practices at CMHC, where PROS participants had had zero involvement regarding who the agency hired to provide counseling and case management services. Therefore, contrary to existing practices, the PAR team wished to be involved in the hiring of a new co-facilitator for their group following Joyce’s

departure. This demand promoted conversations between the PROS Director and the PAR team on the hiring process at CMHC and the PAR team's expectations of the new staff member. The discussions also promoted transparency on the gatekeeping process and staff recruitment methods at CMHC, which offered reassurance for the PAR co-researchers that their recovery was supported by high caliber clinicians, an awareness that was contrary to our co-researchers' preconceptions. The third organizational issue that the PAR team addressed concerned the number of PROS counselors resigning from the agency, which resulted in many PROS participants' cases being assigned to new counselors. The participants perceived a change in the level of assistance provided by the new counselors, namely, the new counselors' reluctance to provide support with translating English notifications that the Chinese participants received – a form of help that the participants assessed as pivotal to their overall sense of wellbeing.

The PAR co-researchers initiated many "firsts" as they addressed the issues that they found to be impacting operations at the agency and the services that PROS participants received. These actions included initiating meetings with the PROS Director and preparing materials to candidly propose areas of growth within the treatment programming, such as the importance of maintaining a PAR platform—an approach to recovery through consciousness-raising methods of spearheading personal empowerment and community activism.

As experts who were committed to taking responsibility for who entered the sacred space of their PAR team, our co-researchers found it essential to be involved in the hiring process and in deciding the requirements that constituted an effective PAR co-facilitator at PROS. The PAR team's authority over their group consequently led to conversations with the PROS Director about hiring practices at CMHC, thereby bringing transparency to administrative decisions that PROS participants were traditionally excluded from. Additionally, the PAR team appealed to

PROS management regarding the importance of program participants gaining assistance with the interpretation of English materials related to Social Security. Through a series of meetings in both small and large group settings and discovering creative methods of mobilizing action on behalf of PROS participants, the team was ultimately successful in 1) advocating for PROS to continue offering PAR in its programming; 2) allowing the PAR team to have input regarding who is hired as team co-facilitator; 3) securing more transparency, accountability, and non-hierarchical decision-making in organizational operations; and 4) simultaneously resolving the issue of PROS participants receiving sufficient assistance with interpreting English materials and staff shortage by creating a new intervention group aimed at addressing social class and Social Security and Disability issues.

CHAPTER V

DISCUSSION

Individuals with serious mental illness diagnoses have historically suffered from institutional, medical, and mandated forms of treatment where they were stripped of enfranchisement and empowerment regarding their own recovery process. Chinese immigrants in the U.S. bearing serious mental illness labels must also contend with oppressive forces such as systemic racism, cultural oppression, and discriminatory experiences. This chapter will begin with an overview of the project, followed by a discussion on resonances between how the existing literature represents Chinese with SMI and the experiences emerged from our PAR collaboration with Chinese co-researchers. Specifically, we will discuss nuances in how Chinese immigrants with SMI express mental health issues, the re-establishment of "face" and personhood through PAR, and the amelioration of SMI symptoms through PAR participation. We will then address a crucial piece to our co-researchers' sense of wellbeing, which is tackling class inequities and how we were able to shift the position of our co-researchers from being disenfranchised to being empowered. Following that, we will examine how we could undo structural, interpersonal, and internalized oppression through PAR and how university researchers' can regain the trust of marginalized groups and fortify stakeholders' opportunity to participate in emancipatory research. The discussion will then move on to exploring the limitations, challenges, and points of tension encountered on this PAR journey. Later, we will discuss the clinical implications derived from this PAR dissertation project. Areas that will receive particular focus include the facilitator's awareness of cultural power and privilege, overcoming challenges to traditional treatment goals, the trial and benefits to tackling tangible

problems, and engagement with community co-researchers in community outreach, research, teaching, and administration.

Overview of the Study

The present study explored the utilization of a PAR approach as part of the recovery process for Chinese people living with schizophrenia in the U.S. Implemented as part of a community-based mental health organization's day treatment program (called PROS), the project represented an attempt to create opportunities for an agency for a highly disenfranchised and marginalized group. For two years, a PAR team consisting of two staff co-researchers and 10 Chinese co-researchers at a PROSpect Place (PROS) program in the Lower East Side of Manhattan were intensely engaged in critical inquiry of the social, political, and cultural influences that have demarcated the participants' experience of living with serious mental illness diagnoses. Utilizing a multicultural and social justice framework approach, we examined the social inequality and marginalization confronted by poor Chinese immigrants bearing persistent and chronic mental illness labels. The team engaged in a series of culturally-supported dialogues on the impact of structural constraints experienced by the co-researchers. Areas examined by the team included such topics as a) experiences and understandings of trauma and mental illness, b) exclusion from full participation in society via the systemic oppression of unemployment, poverty, immigrant status, long-term hospitalization and treatment, and c) recovery through self-help approaches, supportive forms of intervention, and expressions of love and intimacy. The co-researchers found the subject of employment to be crucial to their path towards greater autonomy and citizenship within their social systems. Therefore, the team decided to conduct more thorough research on understanding the occupational challenges experienced by PROS participants and how best to support vocational access for them.

The team embarked on an extensive process comprised of traditional and culturally-informed methods in the development of the project. From conducting a literature review to developing hypotheses, creating and disseminating the survey, interpreting the results, and determining the necessary follow-up and action plans, the co-researchers were involved in every step of the research process. During research meetings, the team analyzed the unspoken, complex social forces that governed the PROS co-researchers' lives, such as the unrelenting stress of poverty and unemployment and the immigration and acculturation process, which they had associated with to the first onset of their psychotic experiences. The reflexive dialogues of the emerging data also expanded our awareness of how our social locations shaped these analyses and allowed us to define actions that were considered meaningful and practical.

Concurrent with implementing the research project was the team's involvement with issues that were occurring at the agency. The team members felt the need to promote activities and groups that were beneficial to them, such as advocating for the PAR team to continue as an ongoing intervention program. The team also identified their own need to have a seat at the table regarding the hiring process at PROS and helping to decide what kind of facilitator was well-suited for a role as their counselor or group facilitator. Furthermore, the co-researchers wanted to address the lack of translation assistance from the new counselors while keeping in mind the shortage of staff and the resulting strain on the assistance that PROS participants receive. The co-researchers took actions to address these issues by discussing and practicing the verbalization of their unique perspectives, as well as posing questions to each other in the team meetings to work through the complicated feelings that emerge from having been persistently silenced. They hosted meetings with the director of PROS and courageously spoke out about their concerns during community-wide meetings. They also created a letter to express their opinions and

suggestions for how the program could meet the needs of its participants while working within the confines of the Office of Mental Health regulations and staff shortage. The team was able to amass signatures from PROS participants who supported these views. After a series of mobilizing efforts, the team ultimately succeeded in a) advocating for PAR to remain as an intervention program at PROS, b) allowing the PAR team to have input on selecting its co-facilitator, c) attaining more transparency and accountability in the agency's organizational operations; and d) developing a new group to specifically provide translation and assistance on all issues related to the participants' Social Security, social class, and disability status. Through the egalitarian and multiculturally sensitive reflexive research processes of PAR, the co-researchers and co-facilitators were able to challenge traditional institutional practices, realize the contributions of their unique perspectives on undoing the unjust processes that have kept Chinese immigrants with serious mental illness labels from full, inclusive participation in their own recovery, and create practical solutions that immediately benefited their recovery.

Resonance with Existing Literature: The Potential for Chinese Immigrants with Serious Mental Illnesses to Enact Change

In this section, correspondences between the current study and existing literature will be explored. First, we will examine how mental health expressions among Chinese with SMI could differ and describe the nuances that we were able to witness through the social justice framework of PAR. Next, we will review the concept of "face," an intrinsic social construct among Chinese, which is often lost due to the stigma and disenfranchisement attached to SMI, and how it could be re-established through PAR. That discussion will be followed by an exploration of how SMI symptoms were ameliorated among our Chinese co-researchers during their PAR participation. Next, we will examine the pressing burden of social class inequities that our co-researchers

continuously confront and the possibility to shift from a disenfranchised position to an empowered one. The possibility of addressing structural, interpersonal, and internalized oppression through PAR will be discussed. Lastly, we will examine how university researchers could regain the trust of marginalized groups to fortify the opportunity for stakeholders to engage in emancipatory research.

Culture and mental health expressions among Chinese with SMI. Scholars within the field of mental health have frequently called for attention to cultural differences and cultural sensitivity in treatment with diverse groups (Sue & Sue, 2012; Vera & Speight, 2003). Often, the literature has highlighted that Chinese values encourage Chinese descendants to maintain essential norms and behaviors, such as minimizing emotional expression and circumscribing personal problems to mainly family circles (Yang & Kleinman, 2008; Leong et al., 1995). Most Chinese limit the sharing of their mental illness diagnoses for fear of stigma that would lead to social exclusion and unemployment, as well as cause jeopardy for those associated with them (Chung & Wong, 2004; Li, Logan & Ng, 1999). Studies have shown that Chinese clients may experience more difficulty opening up to a counselor who is a stranger and that Chinese participants do not indicate a preference to seek mental health providers as a source of help (Leong et al., 1995).

However, our collaboration has suggested that there are nuances to Chinese expressions of strong emotions, and that there may be circumstances under which deep, personal sharing is permissible and even encouraged. While our co-researchers affirmed having restricted the knowledge of their psychiatric diagnoses mainly within the kinship domain, the PAR experience has provided a context for other kinds of emotional expressions and connections to occur even among strangers and peers. For example, Bai-Hua shared an account of how acting upon her

suicidal thoughts had led to immediate hospitalization after Tina shared about her involuntary hospitalization. Such an exchange would be typically considered highly taboo within traditional Chinese culture, and could have subjected both women to extreme forms of stigma including both social exclusion and unemployment, as they would be perceived as "dangerous" and "unpredictable" (Phillips & Gao, 1999). Bai-Hua took the chance to share this deeply personal information to show solidarity for Tina, who also took a risk in sharing her own personal story. Tina initially vocalized her concerns about being seen with peers who she perceived to display more overt signs of mental illness. She was fearful that her diagnosis would be discovered by association with her peers. Therefore, she initially rejected the idea of taking field trips with the PAR team. However, after the PAR team had actively worked on collecting information on social disability and invited a guest speaker to provide a workshop, Tina expressed her trust in the fact that the PAR team valued its team members' interests and apprehensions, as well as the team's commitment to not merely walk away with others' stories but make meaningful connections from them to benefit the group as a whole. As a result, Tina felt more fortitude in sharing sensitive stories about her past, which compelled Bai-Hua's determination to express her own vulnerability to further develop the team members' camaraderie.

These examples suggest that when trust and working alliances are achieved, with a clear understanding that the personal information would be honored, Chinese participants may be more inclined to share their emotional and mental struggles with people outside the realm of kinship. Our co-researchers chose to share intimate details of their psychiatric symptoms to promote group solidarity after knowing that the honest dialogues would contribute positively to personal and collective outcomes. Within the supportive, strength-based premise of PAR, the lens shifted from fear of loss of personal integrity to embracing the challenging aspects of their

mental illnesses to raise each other's courage, support collective risk-taking, and promote liberation from the stigmatization of mental illness and oppression. These reactions add nuance to the view that Chinese suppress disclosing unfavorable health information. Furthermore, our co-researchers' display of interpersonal empathy and connectedness in the company of agency co-facilitators also diverge from the view that Chinese prefer not to seek mental health resources as a source of help. We found that Chinese are willing to openly express their struggles before mental health practitioners, with the caveat that mental health practitioners have earned their trustworthiness in honoring the information as well as credibility to help resolve the issues.

Furthermore, the participants who sought to stay in the PAR team have been in treatment for almost ten years on average. Our PAR co-researchers show strong commitment to their day treatment and have participated in a range of treatment groups, and yet, they represent individuals who have reached a stage in their recovery where they want to look beyond standard ways of engaging treatment. As such, a unique characteristic of Chinese participants who demonstrate participation and longevity in PAR teams may be more prone to taking risks and being responsive to their peers' vulnerability and disclosures with the goal of promoting wellness and unity for the team as a whole. Therefore, a characteristic of Chinese participants who may be drawn to PAR-inspired interventions may be disposed with high engagement level and ready to expand the way they relate and affect their environment.

Re-establishing "face" and personhood through PAR. As reviewed in an earlier chapter, a predominant theme in the multicultural literature regarding Chinese clients is the preservation of "face" to cultivate status in society. One social element of "face" concerns children and parents' lifelong obligation to provide for one another. As previously described, the parent or adult's role is to cultivate filial children who would grow up to provide for their

parents, and immerse in texts and environments that teach Chinese morality of self-restraint, filial obedience and loyalty/ patriotism (Yang & Kleinman, 2008). An individual's failure to adhere to the social expectations within Chinese society has been theorized to be treated as "less than human," equating to a "social death," where the individual is rejected from engaging in social exchange and the social standing of the members belonging in the same social circle are jeopardized (Yang & Kleinman, 2008, p. 399). Chinese with SMI diagnoses frequently suffer from loss of face as they are often denied access from engaging in critical social practices that define their moral personhood in the Chinese community (Yang, Phillips, Lo, Chou, Zhang & Hopper, 2010; Lv, Wolf & Wang, 2013).

Our co-researchers experienced similar sufferings, from being excluded from meaningful partnerships and building a family to finding competitive and gainful employment. Being impoverished also limited team members' ability to engage in social activities or provide for their parents or children. The sense of demoralization from lack of civic and social participation experienced by our co-researchers was a salient theme in our team discussions.

Yang and Kleinman (2008) have recommended "re-moralization" counseling as an anti-stigma intervention that specifically addresses the physical and emotional consequences resulting from loss of face or moral status. "Re-moralization" counseling entails a combination of multiple approaches, including the use of cognitive schemata, 'coaching' strategies, and multiple-family groups to target individual and family stigma, and government-sponsored dialogues to target discriminating attitudes in healthcare. The authors suggested that "formal, face-to-face dialogues would provide a non-confrontational forum to discuss how physician actions contribute to the loss of patients' and family members' moral status" (Yang & Kleinman, 2008, p. 403) and noted

that stigmatized individuals involving in the dialogues would need to be provided equal status and authorized sanction.

PAR processes appear to support the goals suggested in "re-moralization" counseling yet also extend beyond via its creative, relational, and structural utility. A paradigmatic feature of participatory action research is that it is strengths-based and fosters connectedness among all individuals involved (Nelson et al., 1998). In this way, PAR mitigates the perception that individuals with SMI are unable to attain meaning, value, and recognition in that they can act as problem-solvers that advocate for and improve community members' lives (including those in positions of authority, such as managerial staff members). Our Chinese PAR co-researchers directly challenged the cultural presumption that they lack emotional and moral restraint by working innovatively, methodically, and collaboratively. Specifically, attitudes that people with SMI are violent, dangerous, unpredictable, lazy, irresponsible, and/or chronically and persistently too ill to work were counteracted as co-researchers challenged the status quo through their inquiry and data-gathering. Furthermore, our co-researchers changed longstanding unjust practices by deciding what type of intervention was needed and who it was going to be enacted by. They challenged each other and the staff for more accountability by calling for transparency and follow-up meetings, and demanded lasting change through their own action-taking by creating a PAR legacy. Our co-researchers were given a seat at the table and no longer played the "passive" and "withdrawn" roles but gradually saw themselves and each other as individuals who deserved full moral status and acceptance, a process that resembled what Yang and Kleinman (2008) described as a "re-moralization process".

Amelioration of SMI symptoms through PAR participation. A surprising but logical by-product of participating in PAR according to our co-researchers was the potential for SMI

symptoms to be mitigated regarding their perceived impact on the bearers of those symptoms. Our co-researchers described conventional forms of treatment as focused on relapse prevention without examination of social and environmental stressors. These stressors triggered them to "feel defeated over and over again," as Bai-Hua termed it, adding that "When every opportunity to do well is taken away from you, you lose hope after continuous defeat and repeated loss." By contrast, they reported that the PAR experience "stood out" and "gave hope" as compared to other treatment programs because team discussions were "shaped by our interests and what we knew to be important" (Grace, May), rather than focusing unnecessarily on subjects that clinicians defined as necessary for their clients. The inclusivity of PAR permitted a space where our co-researchers' authentic perspectives and desires could emerge and be affirmed. The co-researchers guided the pace and direction of the dialogues according to what mattered and affected them, their families, and their cultural values. Their involvement in examining and acting against sociocultural forces of power, inequity, discrimination, and oppression through practical means moved the focus away from the deficits defined by biomedical standards. As they began connecting their personal journeys to the knowledge they gained from their literature review and from gathering community resources, they perceived the focus and re-experiencing of their symptoms to diminish and be replaced by a galvanizing sense of hope and resolve. According to Grace:

> Watching the videos on youth participatory action research, hearing about guest speakers' experiences, and talking to my team members helped me understand my own journey. I found my mood improving and I did not hear the voices as much when I was engaged in our discussions and activities. This awareness comforted

me and made me want to communicate and take more action. PAR really affected me (May 2015).

PAR conversations created opportunities to generate optimism and enthusiasm as the team brainstormed ideas on how to fix problems for a collective change. Lai-Do described that her voices typically emerged when she felt lonely and in need of companionship. She appreciated the voices because they readily told her jokes and made her laugh, bringing humor to ameliorate painful circumstances. However, Lai-Do found the voices to rarely surface during PAR meetings. She attributed this awareness to the opportunity to fully immerse herself in meaningful conversations that thoroughly captivated her attention. For Patty, the chance to ask about her health concerns without feeling judged helped her symptoms of obsessive compulsivity. Specifically, she felt less distracted by intrusive thoughts when she was able to openly talk about her weight gain and metabolic concerns after finding out that others related to her health anxiety. The team's ability to integrate health-conscious behaviors in its activities, such as doing jumping jacks together and practicing developing a survey on physical exercises, further transformed her fears and tendency to isolate. Rather than withdrawing into her phobias, Patty found herself able to focus on new subjects and channel her interests by planning creative activities for the team (i.e., exploring restaurants together and charting a route for the PAR team to commute).

Acceptance, community belonging, and mutual support are accepted notions of peer support groups for individuals suffering from SMI (Davidson, Chinman, Sells & Rowe, 2006; Repper & Carter, 2011); the effects of learning through action-taking and activism on the amelioration of SMI symptoms are less articulated in the literature. Ochocka et al. (2006) reported that their participants' consistent participation in Consumer/ Survivor Initiatives resulted

in an increased sense of empowerment, stability in work, education and training, and sense of control over symptoms by researching about illnesses and becoming more active in treatment decisions. Similarly in our PAR partnership, the alleviation of symptoms at the moment seems to occur during the "doing" portions. Behaviors could range from active listening to asking questions or taking more tangible actions, so long as the individual is earnestly involved and/or genuinely interested in the discussions, decision-making, and action. The power of reflection, collaboration, and the co-creation of knowledge through participation seem to bring contextual meaning and purpose for the individual and the collective, which in turn is perceived to shrink the manifestation of SMI symptoms and channel the confluence of environmental and psychological conflicts through constructive outlets. As Ah-Tung described,

> The urges to smoke are not as strong when I am in this group. The fears, shame, and loneliness are not as strong, and I don't need to turn to cigarettes to help me cope with the overwhelming feelings. The more I talk about the things that distress me, the more feedback I get. The more I learn the less confused and suspicious I become. I worry that I say too much and occupy too much time, but talking things out helps me feel relief afterwards. We use our brains to untie the knots. (February, 2014)

Tackling class inequities and moving from disenfranchisement to empowerment. Our co-researchers occupy multiple marginalized identities, one of which is poverty, where its discriminatory effects have overshadowed their daily lives and relationships with their community. Their experiences of the far-reaching impact of poverty echo those mentioned elsewhere in the literature, including affective reactions of hopelessness, fear, worry, chronic vigilance (Chen & Mathews, 2003); social isolation and exclusion (Smith, 2010); sense of

powerlessness (Goodman, Pugach, Skolnik & Smith, 2013); sense of inferiority, self-doubt, and low self-worth (Goodman et al., 2007; Young, 2000; Friere, 2004). Poor families consistently show low utilization rate of mental health services, which community researchers in other participatory projects have attributed to the potential mismatch between mainstream psychological health practices and the struggles faced by impoverished families, such as food and housing insecurity and the inability to meet other basic survival needs (Goodman et al., 2010; Smith & Romero, 2010). Our Chinese co-researchers have shared similar struggles with finding effective interventions to address the pervasive impact that economic stressors had on their lives. As Tina stated,

> That is my reason for being here…I decided to switch over my treatment to this agency specifically to get help for my SSDI benefits. Taking medications, attending a day treatment program or staying at home are neither helpful if someone cannot help me with my SSDI. Not knowing if my status is up to date has made me very anxious and depressed. Without it (SSDI) I cannot survive.

By making the team's concerns over economic stressors explicit and sharing an understanding together of how poverty overshadowed and impeded our co-researchers' well-being (Smith & Romero, 2010; Goodman et al., 2007), we were able to address these issues in a reality-based, tangible manner. The social justice framework of PAR, in fact, privileged our goals of finding pragmatic methods of healing and recovery. Community team members, for example, invited a guest speaker from the Social Security Office and the team's university/agency team members interpreted for the speaker. Together the team learned the formula for calculating the monthly benefits and how income could impact the amount that participants were eligible to receive, as well as advocating for a new program that focused

specifically on social class and social disability issues. Finding out that employment did not terminate our co-researchers' eligibility for SSI/ SSDI, and that the aggregate of their income and Social Security benefits could surpass their current monthly benefits offered our co-researchers a sense of realistic hope. The information that employment would not jeopardize the participants' benefits prompted the team to tackle another pressing issue – how to support vocational opportunities for people with SMI, thus the emergence of a research project.

By pragmatically addressing our inquiries, the team inadvertently uncovered a crucial piece of information regarding our co-researchers. Namely, the team dealt with a significant underlying conflict that our co-researchers' struggled with – that seeking a job might amount to less income and termination of one's eligibility for Social Security. The dialogic praxis and act of responding to the concerns pragmatically co-created knowledge that helped the team take further collective action with that knowledge (Brydon-Miller et al., 2003). After the co-researchers' legitimate concerns were explored and understood, the team moved on to examining the next problem of achieving vocational success without having their current benefits threatened. In that vein, our co-researchers transformed their position as helpless "unmotivated" welfare recipients to empowered action researchers on issues of poverty and employment for poor Chinese immigrants with chronic and persistent disease labels.

Undoing structural, interpersonal and internalized oppression through PAR. Our PAR collaboration unveiled its capacity to undo some of the corrosive effects of stigma and oppression that caused devastation across intrapersonal, interpersonal, and group domains in our co-researchers' lives. Individuals with SMI struggle from high degrees of systemic social exclusion, isolation, and invisibility, which can lead to the internalization of their own subordinate position (Corrigan & Rao, 2012; Brohan, Sartorious & Thornicroft, 2010; Van Dorn,

Swanson, Elbogen & Swartz, 2005; Lee et al., 2006; Lam et al., 2010). For individuals who suffer from SMI conditions, their internalized oppression and stereotypes could look like "I am dangerous," "I am afraid of myself," "I am incapable," (Watson, Corrigan, Larson & Sells, 2007), with similarly stigmatizing perceptions of others with SMI (e.g., finding them difficult to work with, not wanting to marry into the family, and not wanting to be physically or socially close with them) (Van Dorn et al., 2005). Within the organizational structure, marginalized individuals and minorities are further rendered powerless and victimized by decisions and structures that perpetuate their subordinate position. For example, individuals with SMI are often labeled as "patients." They may be believed to pose a threat to the community and incapable of making sound decisions, and are therefore often mandated to treatment where decisions are made for them (Harangozo, et al., 2014; Lee at al., 2006; Horsfall, Cleary & Hunt, 2010).

Our PAR experience demonstrated a capacity to counteract some of the oppressive mechanisms embedded in the social, cultural, and institutional structures of our co-researchers' lives. Our team challenged the status quo within their immediate lives, and we used the PAR platform to increase our co-researchers' visibility so that their opinions would be better heard and accounted for. Furthermore, the mission of our projects gave us no reason to hide, isolate, or avoid associating with each other because of SMI symptoms, but instead united us to work closely together both privately and publicly to pursue individual and collective redress of practical matters. We also found that credibility for all team members increased as all contributed through their own unique way of propelling the group toward tools of self- and group-determination. We were interdependent with regard to each others' skill sets in the accomplishment of projects. Co-researchers who were more fluent between Cantonese and Mandarin were more active with interpreting our discussions and dialogues, co-researchers who

were more comfortable with discovering community resources were more energetic in helping the team plan neighborhood outings, and co-researchers who were more comfortable with operating a desktop readily assisted with those tools. Ultimately, our co-researchers were more able to see themselves as important and capable citizens who held the key to resolving problems at their agency on behalf of themselves, other PROS participants, and the staff.

University researchers' opportunity to regain the trust of marginalized groups and fortify stakeholders' opportunity to participate in emancipatory research. Immigrants and people with SMI have been subject to severe forms of maltreatment due to exploitative research and treatment practices towards minorities and marginalized groups (Kemmis & McTaggart, 2005; Green, 1997; Sue et al., 1998). Psychiatric survivors have long called for attention to medical practices that perpetuate demoralization and loss of self, in which decisions are often made for clients and things are done to them without their permission, consent, or understanding, whether in research or other contexts (Deegan, 2003). Community participants with SMI are rarely afforded the opportunity to direct the way they are represented or how their knowledge and involvement is being used in research. Our co-researchers expressed similar concerns over recklessness in the use of their protected information. For example, Ah Tung shared his devastating experience of finding out that his picture was used to promote a mental health website without his knowledge or consent. He also endured long, grueling hours of questioning when he "volunteered" to be a research subject without ever having been fully informed in advance of the extent of his participation. Collectively, our co-researchers spoke of the sense of exploitation, lack of respect, and lack of closure when researchers walk away without their knowing what is being done with their information.

Our PAR partnership taught us that community members and academic researchers could be liberated from oppressive research practices and together create a meaningful legacy. PAR required us, the academic outsiders, to approach the collaboration with a pre-project phase to ensure that every community participant had a preview of the experiential processes of PAR, with the "joys and possibilities of democratic research," prior to further volunteering as a co-researcher (Fine & Torre, 2006, p. 255). Our procedures helped to make transparent the usually "private" mechanisms behind building a project and clarified the institutional regulations put in place to safeguard confidentiality, ethics, and safety. Discussion of power differentials was explicit as we embarked on our consensual decision-making from the beginning stages of the partnership. These processes served as checks on the oppression of traditionally dictatorial research practices so that we could generate an emancipatory legacy whereby future readers, teachers, and learners could also be participant-consumers of morally-grounded, ethical research.

Limitations and Challenges

A narrative approach to the presentation of a PAR project has been supported in its effectiveness to validly capture the developmental progressions and successive stages of PAR activities and outcomes (Smith, Rosenzweig & Schmidt, 2010). This dissertation study followed suit in its narrative framework yet met challenges in the team co-researchers being monolingual Chinese, and having the dissertation writing being completed by me, a doctoral candidate. The writing was guided by the notes, reflections, diagrams, pictures, and quotes collected during the PAR team meetings as part of my commitment to infuse the co-researchers' voices and collective efforts throughout. I also worked to present the team's developments as closely as possible to the lived process of the project. In the spirit of feminist, multicultural, and PAR philosophy, the reader and writer must still remain cognizant of *whose* voices are being represented and how

their actions and findings are being represented. There might invariably be different choice points for exploration and discussion if the traditional composition of a dissertation committee were modified for more systematic incorporation of community members' voices and writing. Such would require academic institutions' willingness and ability to transform its structure to "redress inequality and redistribute power" (Sarri & Sarri, 1992, p. 100) in the "monopoly on the definitions and employment of knowledge" (Reason, 1994, p. 328), and to accept the work of the student-researcher as legitimate while encouraging community participation. The current format of a dissertation defense does not permit a non-academic PAR co-researcher, who carries an outsider position, to participate as a member of the hearing in the academic setting. The dissertation defense hearing also cannot be held at the community agency where the PAR project collaboration took place. Similarly, a community expert/co-researcher cannot participate in the data or defense hearing as a dissertation committee member. Since the goal of community-based PAR partnership is to build strength and resources in the community and to ensure that all action, knowledge, and findings will be applied appropriately to benefit all stakeholders, then the infrastructure of academia would need to evolve accordingly so that conventional institutional structures do not restrain research knowledge and perspectives.

While this project was regarded as a successful undertaking in bringing PAR to life with historically marginalized U.S. Chinese immigrants with an SMI diagnosis, the team was facilitated by agency counselors and a university-based counseling student throughout the collaboration. Although our co-researchers preferred the modality of having a facilitator from the academic setting and a facilitator from the agency, it would have been more ideal if the team meetings could have been facilitated by a community member expert or a co-researcher-turned-co-facilitator. While the team's facilitators have shown commitment to learning PAR principles

and creating fair and supportive relationships in addressing health and ecological concerns, there remain institutional, social, and cultural influences inherent in the credential carried by the team facilitators. As much as the co-facilitators' attempted to stay mindful of the power carried through their status and identities through supervision and reflective iteration with the team members as power dynamics occurred in the moment, it is still possible and likely that different paths might have been taken if the team were to be co-facilitated by a peer specialist or a seasoned PAR co-researcher turned facilitator. A client-participant would likely be attuned to a different set of complexities and dynamics occurring in the room that would shape projects and outcomes differently.

"Points of Tension." Paralleling Dickson and Green's account of unanticipated obstacles, I also found myself caught in dilemmas that perplexed me in the moment or caused disquiet in me when I further reflected on the process **(**Dickson & Green, 2001, p. 477). There existed moments where I felt uncertain about my level of influence and/or how much of my personal needs were affecting my input. An example stems from an early time in the collaboration where one of our PAR activities was to create our own power ladder where we identified where we stood among the people and staff who were part of the agency's family. Our discussion of the activity revealed that our co-researchers consistently placed themselves at the bottom of the ladder partly because everybody else on the list was addressed either as Doctor or Ms./Mr. versus the PROS participants, who were mainly addressed by their first name. Although the reasons for our social positions were multifactorial, I believed that we needed to address the unfair treatment starting from the microcosm of the team. I encouraged my co-researchers to address me by my first name and suggested that we could also address all team members by Ms. or Mr. The suggestions did not seem to catch fire among my co-researchers initially until it was

further revealed to me that there were implications in my co-researchers' lives that I was unaware of, such as being perceived as being "difficult," "disrespectful," or "challenging." Such behaviors could be assessed negatively and consequently be reflected in their records if they were overheard by other staff members addressing any staff by their first name. Gradually, as our co-researchers began to truly experience a shift in their power and ownership over their team did they begin to address me and my co-facilitator by our first names spontaneously.

A PAR journey contains ever-evolving agendas and unforeseen changes that present incredible learning experiences for a traditionally trained researcher (Smith, Rosenzweig & Schmidt, 2010). Although I have been taught considerable skills as a multicultural counseling psychology student on providing culturally-sensitive psychotherapy, the PAR collaboration with community co-researchers further expanded my understanding and beliefs of what constituted progress, completion, and effective change. One example details the period of when we created the survey. As a student trained in health service psychology, I held the expectation that we would keep refining the questionnaire until each survey item was perfected. After several revisions, my co-researchers believed that it had reached the stage where the survey was ready for dissemination, and they wanted to begin experiencing the next phase of research development. During data calculation and analysis of the outcome, our co-researchers reflected on possible confusions and ways of reframing questions to further narrow items or answer their curiosities. By co-creating a new process that was novel to both the insider and outsider, momentum was ultimately gained, and co-researchers felt encouraged and motivated by the success of their recruitment while also gaining newfound awareness of the research process.

PAR's ever-changing terrain also results from dealing with real-world situations where community team members are managing complex issues that stretch across macro-level systems

and also influence the microcosm of the research team. One of PAR's characteristics is that it challenges traditional researchers to embrace the real demands that community members frequently encounter and often have no control over. In the case of our co-researchers, numerous issues needed to be addressed simultaneously and reprioritized, meaning that goals and objectives could not always be neatly defined or distilled into small measurable units in the way that a traditional research plan stipulates. For example, our PAR team was at a crossroads when we had completed analysis of the survey data but were undermined by organizational changes (i.e., shortage of staff, budget cuts, the effect of participants being assigned to new counselors who were unfamiliar with the culture of the agency, and the fate of the PAR team). The team decided that troubleshooting problems at the agency level were most pressing at that time and therefore had to delay the dissemination of the survey findings to problem-solve the organizational issues instead. I experienced bewilderment in the face of the institutional demands and external challenges that were imposed continuously upon my community co-researchers. The confusion and helplessness that I felt from the oppressive structures were only glimpses of stressors that my co-researchers had to contend with perpetually.

Clinical Implications

Facilitator's awareness of cultural power and privilege. In accordance to PAR's philosophy for social equity, a PAR team co-researcher from a professional setting – who in many cases, will be regarded as a facilitator -- should carry a strong working knowledge and experience base in the area of multiculturally-competent practice. PAR's commitment to social justice requires that those implementing its agenda should "raise critical consciousness and promote change in the lies of those involved – changes that are in the direction and control of the participating group or community" (Kidd & Kral, 2005, p. 187). To ensure that project decisions

truly benefit community co-researchers and that consensus is achieved in a democratic manner, the facilitator needs to be sensitive to issues of sociocultural power and their impact (the amount of power and privilege that an individual receives in society based on cultural identities such as race, gender, sexual identity, social class, ability/ disability status, education level, occupation, etc.) (Whaley & Davis, 2007). A culturally attuned facilitator "possess[es] knowledge and understanding about how oppression, racism, discrimination, and stereotyping affect them personally and in their work… [and] have knowledge about sociopolitical influences that impinge on the life of racial and ethnic minorities" (Sue et al., 1992, p. 482).

Facilitators who enter PAR without a commitment to examining their own worldviews based on their social location and the inherent power, privilege, biases, and stereotypes constructed within that worldview could unknowingly do harm while navigating the decision-making, dialogues, actions, and goals (Sue, Zane, Hall & Berger, 2009). Too often, outsider experts (with their outsider cultural worldview, socialization, and training) impose beliefs, conceptions, and biases that drastically differ from local insider knowledge of the culture, tradition, issues, and resources that exist within the community. Outsider experts often enter a community with the mindset of what should be researched, how it should be researched, and who should be the objects of the research. With the power that society unfairly grants to individuals of certain identities (i.e., Whites, male, heterosexual, individuals with professional status, people from middle-upper class, able-bodied individuals, etc.), facilitators need to be aware of how social privileges of outsiders could inadvertently overwhelm the needs of diverse community insiders and unknowingly collude with oppressive institutional and social systems.

A multiculturally-competent facilitator must understand, appreciate, respect, and be exposed to diverse cultural experiences while intervening and advocating on behalf of clients

(Alvarez & Chen, 2008). Multicultural group psychotherapy skills and feminist pedagogy also offer important skills and guidance in addressing power relations and group dynamics in the here-and-now. Our PAR collaboration repeatedly required us to examine unspoken social influences that were affecting our interactions in the moment. Many times, there was a need for me to point out my biases in terms of my social location regarding issues such as biomedical models versus indigenous explanations of SMI symptoms. We also needed to work at undoing identity-related stigmatization and oppression as they were happening in the room. For example, our co-researchers were initially doubtful that agency management would permit that PAR team to continue its programming given that they had never experienced autonomy or power with regard to any programming decisions. However, continuously highlighting the credibility of their unique experience and their knowledge of what improves their well-being, as well as critically examining the status quo and calling out inequitable practices as a team cemented our pursuit of democratic practice. Gradually, institutional and internalized oppression lessened their hold on the process within our co-researcher group. Co-researchers began to exercise their voices to hold meetings with the agency's management to discuss their expectations for their PAR team, as well as other issues pertaining to the agency and their treatment.

Overcoming challenges to traditional treatment goals. PAR's approach supports all co-researchers' ability to make relevant and impactful changes in their everyday lives. The meaning and value gained from the milestones reached through our collective actions contrasted with the sense of demoralization our co-researchers reported feeling in association with the way treatment and recovery are clinically defined. Specifically, they did not find clinical treatment goals to be entirely translatable to meaningful differences in their lives. With regard to these elements, professional co-researchers will find opportunities to learn and develop their own

clinical approaches. For example, my experience as a psychology extern resonated with my co-researchers' experiences in terms of feeling limited and ineffective in my therapeutic collaboration with my clients. I frequently felt restricted in my ability to support my clients to experience true autonomy and personhood when operating from the conventional deficit model of mental health and psychiatric practices. Rarely, our focus on medication adherence and symptom management converted into observed overall improvement in quality of life. Our team's discussions helped everyone consider that the protocoled techniques taught in clinical settings are brief, simulated, and based on middle-class Western perspectives that held little relevance in our co-researchers' everyday social exchanges within their ethnic enclaves. Traditional one-to-one or group clinical treatment settings also failed to offer an explicit focus on practical, local, and collective issues that directly improved their lives and relationships with peers, community networks, or family members. For example, our co-researchers spoke about how being able to manage their SSI/ SSD issues directly alleviated the stress that would be otherwise be imposed on their family because their family members similarly suffered from poverty, language barriers, or a lack of know-how in maintaining benefit eligibility.

On the other hand, goals chosen by PAR teams can be centered around a collective goal. As all team members witnessed the interconnectedness of their actions with one another, and how we all represented vital links in creating change, we committed ourselves to tangible goals that surpassed the achievements that our co-researchers had seen as possible for themselves. Furthermore, the creative accomplishments advanced in the PAR team remedied some of the re-traumatization that our co-researchers described from feeling as though their lives had remained in stalemate and showed little meaningfully observable improvement as "one year turned into 10." Our co-researchers expressed being in favor of modifying treatment plans to incorporate a

more holistic approach where well-being and progress in recovery could be assessed by criteria such as level of connectedness and meaningfulness that participants felt regarding their relationships to their peers, families, and the agency. This approach seemed to assist with the identification of goals that are grounded in contextual relevance, cultural purpose, and civic participation, with the overarching aim of supporting participants to experience themselves as full citizens of their community rather than as mentally ill patients who should be relegated to psychiatric institutions.

PAR also bears relevance on how the concept of face could be utilized to rebuild moral standing and social credibility for Chinese participants in psychotherapy or mental health services. PAR's distinguished feature entails having marginalized community co-researchers to take charge in determining areas that most impact them and require action and change. Following the guidance presented by Chinese community members naturally paves the way for addressing their most pressing issues, thus directly targeting culturally-relevant problem areas. Within the context of mental health agencies serving Chinese participants, privileging face concerns works hand-in-hand with overarching missions of mental and emotional wellbeing as defined by PAR. Specifically, the focus on developing civic participation and social connections correlate closely to the Chinese cultural belief that social relationships and roles constitute the core of the self (Hsu, 1971b). Furthermore, individuals are considered interrelated, thus, if all act in the interest of the group, the individual and their group shall be harmonious and prosperous (Bond & Hwang, 1986). Therefore, mental health with Chinese individuals utilizing a PAR approach could benefit from following the cultural directives provided by the participant as well as empowering change by expanding the issue of concern and making explicit connections to rebuilding moral standing and trust with the people who are impacted by the issue.

The challenges and benefits of tackling tangible problems. One of the greatest powers of PAR in a setting such as this one is the potential for mental health practitioners to be guided by needs and issues as expressed by their community co-researchers and being afforded the opportunity to build trust and rapport by directly problem-solving issues together. Traditional modes of therapy would instead argue for and prioritize the need for established clinical boundaries, with warnings to therapists to be wary of manipulation or re-enactment. As previously stated, ethnic Chinese and Chinese immigrants (along with other ethnic groups) hold suspicions toward mental health providers understanding their concerns, and do not always find that practitioners are culturally aware and unbiased in their treatment towards them. In our work with Chinese immigrant co-researchers, we tackled co-researchers' concerns about Social Security and disability benefits in the early stages of the collaboration. We worked together to seek out the answers to the co-researchers' questions about how their benefits might get impacted. Mental health practitioners are typically trained to assume that they should only concern themselves with conventionally-defined psychological issues, and matters related to social welfare would be relegated to social workers or administrative staff. However, from a multicultural and strengths-based perspective, the people with whom we work are acutely aware of the issues that impact their emotional well-being, and an equitable collaboration that priorities their concerns is key to unlocking the knowledge, awareness, and resources that will support clients in resolving them. Our position as supporters and facilitators to our co-researchers' pragmatic goals catapulted rapport in our group and bypassed layers of skepticism. As Tina attested:

> I feel safe talking about my situation in this team. My wishes and concerns get taken seriously and we actually do something about them. I know why we are

> doing certain things and how they are benefitting me. That's why I feel that I can be vocal in this group.

Ah-Tung felt similarly and shared,

> This is how [we] know that what we are doing is right. I used to always doubt myself and become very confused and negative because I am very hard on myself. At PAR, I feel much more confident even if I say things that do not agree with other people. I still know more about what is going on.

Engaging co-researchers in community outreach, research, teaching, and administration. PAR co-researchers like ours have great potential to create a positive impact in terms of the way research is implemented in their communities. With deep, innate understanding of the issues that are impacting their communities, community co-researchers hold the keys to answering complex health issues and the motivating and environmental factors affecting their everyday lived experiences that outsiders are shielded from. Community co-researchers' insider position, sensitive discernment of local issues, and a stake in community health, can galvanize community members into participating in liberation research and increase retention. Indeed, throughout the two years of our PAR collaboration, the recruitment efforts for our PAR team and survey participation demonstrated considerable success and only two members had discontinued participation in the PAR team. Furthermore, during our program-wide survey recruitment, all PROS participants who attended the meeting volunteered to participate in the survey.

One of the ultimate goals of PAR is to ensure that the research and actions generated from the collaboration benefit and stay within the community. PAR actions and data all aim to develop solutions and interventions that could have a lasting and sustainable impact on the

community. PAR co-researchers can be involved in managerial and administrative positions to support the service implementation and operational management of PAR-inspired solutions. For example, our PAR co-researchers were involved in creating the curriculum of the PAR program and served as consultants to the new group on social class and social disability issues.

Community PAR co-researchers' understanding of community complexities and ecological perspectives pertaining to local issues create integral learning material for government agencies, service providers, students, and trainees. Community members' instructional input on cultural sensitivities and insider knowledge can support multicultural and feminist training and solutions that target structural influences and microcosmic factors. Staff, trainees, and students would especially benefit from understanding how stereotypes, biases, worldviews and power dynamics impact effective service implementation. Community PAR co-researchers could also be involved in grant-writing alongside partners who hold academic, teaching, administrative, and government positions. Culturally and contextually-based measurements carry acceptability, validity and reliability in their research approach and solutions that would likely enhance funding opportunities. Ultimately, it is believed that systemically employing community PAR co-researchers across government, administrative, clinical, supervisory, teaching, research, and advocacy levels would aid in achieving democratic and emancipatory participation where communities are protected and empowered and complex social problems can be equitably resolved.

Concluding Comments

Historically marginalized and living in disenfranchised communities, Chinese immigrants with SMI diagnoses in the U.S. continue to face health disparities and social exclusion as their complex challenges are misconceived and their voices left unheard. Traditional Western

psychiatric treatment and research are derived from and perpetuate a status quo wherein interventions are culturally mismatched and community members are disempowered from participating in cultural and civic duties that promote personal and collective wellbeing. This dissertation project represents the first known attempt to support U.S. Chinese immigrants suffering from SMI in having their perspectives, decisions, and actions incorporated at institutional levels to disrupt the oppression, discrimination, and exclusion that obstruct their paths to meaningful recovery.

Within the project, PAR was conceived as a viable approach whereby academic facilitators were partnered with local Chinese immigrants with SMI diagnoses as co-researchers. The aims of the collaboration were to address contextual issues through reflexive dialogue, culturally-anchored activities, and solution-focused actions to promote interpersonal connection and ownership of community members' ability to resolve practical issues and create mutually-beneficial change in a sustainable manner. The action steps that emerged from the PAR team meetings were simultaneous, cyclical, yet forward-moving. The collaborative efforts were manifested in one specific location, but worked dimensionally to address cultural, political, and structural matters affecting the concerns of different people (staff, participants, administration, and academic support team). The social and service reforms were complex and multifactorial, yet they were accomplished by the collaborative efforts of co-researchers who are traditionally marginalized, silenced, and labeled as passive and chronically-ill patients.

PAR appeared to be a rewarding and credible approach for this team of PROS co-researchers and academic co-facilitators in creating personal and systems-level change. Our team members learned about each others' unique traits and qualities and witnessed personally meaningful transformations that are rarely represented in the literature. We observed that through

authentic, trusting rapport developed through relevant actions and tangible outcomes, our Chinese co-researchers confided deeply personal emotional dilemmas in solidarity of each other's recovery. *Face* was an essential element to participating in cultural and social exchanges, and we found that it could be experienced and restored as our co-researchers increasingly took part in guiding conversations and initiating meetings and actions rooted in changing maladaptive and non-inclusive institutional practices. We further observed that as our co-researchers engaged in purposeful collaborations that were shaped by their interests and concerns, psychiatric symptoms were reported to carry less influence in the here-and-now. Discussions were no longer confined to the individual managing of aberrant states but were directed toward examining and challenging ecological concerns where racism, discrimination, stigma, and oppression persist in institutional practices. As we traversed through a research process comprised of both traditional and unconventional methods, our co-researchers expressed feeling invigorated to engage in more applied community research.

In this project, PAR demonstrated its potential to assist individuals in promoting responsibility and ownership regarding their own well-being as well as that of their peers. As academics continue to explore the continuum of equitable research, service, teaching, and administration, involving community co-researchers throughout these domains seem crucial in developing strength-based, creative services and training premised on cultural and socially-just perspectives that mutually benefit all stakeholders.

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Appendix A

Informed Consent

Teachers College, Columbia University
525 West 120th Street
New York NY 10027
212 678 3000
www.tc.edu

INFORMED CONSENT

DESCRIPTION OF THE RESEARCH: You are invited to participate in a collaboration to share your experiences, knowledge, and expertise on issues that are important to you. This collaboration can allow us to promote conversations that are important to the service users, help foster connectedness and relationships, learn tools to carry out research and to take action on issues that are relevant to you and other service users. This collaboration can potentially become a dissertation in which you are a co-researcher because of your participation. The collaboration will be conducted with a Ph.D. student and take place at Hamilton-Madison House.

RISKS AND BENEFITS: The risks associated with this collaboration are potentially fatigue, boredom, or discomfort from the group discussions. In such an instance, you have the option to leave the team temporarily or permanently and/ or to work through the issue inside or outside the group setting. Potential benefits to this collaboration are the opportunity for connection with other co-researchers on issues that are important to you. You may experience empowerment and connectedness through the co-creation and sharing of knowledge on community advocacy. As such, the research has the same amount of risk students will encounter during a usual classroom or community outreach activity.

PAYMENTS: There is no payment for your participation.

DATA STORAGE TO PROTECT CONFIDENTIALITY: All participant information will be held confidential and pseudonyms will be given and used in all reports. In the event that you would like to be an identifiable member of the research team (such as in the knowledge dissemination stage), a conversation will take place during which you can decide who are the important members (i.e. your counselor, the co-facilitator(s), the Director of PROSpect Place, etc.) to help you discuss your choices and its implications. All reports will be kept in a locked container in the investigator's office. Data files will be kept on the investigator's computer and will be password protected. Only the investigator and the research team will have access to reports and data files generated from the project.

TIME INVOLVEMENT: Your participation will take approximately 1.5 hours a week. The duration of the collaboration depends on your decision to participate in the group, which is completely voluntary.

HOW WILL RESULTS BE USED: The results derived from this collaboration will be potentially used for the facilitator's doctoral dissertation. The dissemination of the knowledge produced from this collaboration may also take the form of conference presentations, presentation meetings, journal publication, or educational purposes.

TEACHERS COLLEGE, COLUMBIA UNIVERSITY
INSTITUTIONAL REVIEW BOARD
Protocol # 13-320
Consent form approved until 6/24/2014
IRB Signature SH/K-A

Appendix B

Participants' Rights

Teachers College, Columbia University
525 West 120th Street
New York NY 10027
212 678 3000
www.tc.edu

PARTICIPANT'S RIGHTS

Principal Investigator: Joyce Wa Yung, M.A., M.Soc.Sc.

Research Title: PAR Collaboration in the Context of Immigration, Poverty, and Mental Health

- I have read and discussed the Research Description with the researcher. I have had the opportunity to ask questions about the purposes and procedures regarding this study.
- My participation in research is voluntary. I may refuse to participate or withdraw from participation at any time without jeopardy to future medical care, employment, student status or other entitlements.
- The researcher may withdraw me from the research at his/her professional discretion.
- If, during the course of the study, significant new information that has been developed becomes available which may relate to my willingness to continue to participate, the investigator will provide this information to me.
- Any information derived from the research project that personally identifies me will not be voluntarily released or disclosed without my separate consent, except as specifically required by law.
- If at any time I have any questions regarding the research or my participation, I can contact the investigator, who will answer my questions. The investigator's phone number is (212) 720-4569.
- If at any time I have comments, or concerns regarding the conduct of the research or questions about my rights as a research subject, I should contact the Teachers College, Columbia University Institutional Review Board /IRB. The phone number for the IRB is (212) 678-4105. Or, I can write to the IRB at Teachers College, Columbia University, 525 W. 120th Street, New York, NY, 10027, Box 151.
- I should receive a copy of the Research Description and this Participant's Rights document.
- If video and/or audio taping is part of this research, I ( ) consent to be audio/video taped. I ( ) do NOT consent to being video/audio taped. The written, video and/or audio taped materials will be viewed only by the principal investigator and members of the research team.
- Written, video and/or audio taped materials may be viewed in an educational setting outside the research

  ( ) may NOT be viewed in an educational setting outside the research.

- My signature means that I agree to participate in this study.

Participant's signature: _____ Date:____/____/____

TEACHERS COLLEGE, COLUMBIA UNIVERSITY
INSTITUTIONAL REVIEW BOARD
Protocol # 13-320
Consent form approved until 6/24/2014
IRB Signature SH/KA

Appendix C

Investigator's Verification of Explanation

Name: _____

Investigator's Verification of Explanation

I certify that I have carefully explained the purpose and nature of this research to _____ (participant's name) in age-appropriate language. He/She has had the opportunity to discuss it with me in detail. I have answered all his/her questions and he/she provided the affirmative agreement (i.e. assent) to participate in this research.

Investigator's Signature: _____

Date: _____

TEACHERS COLLEGE, COLUMBIA UNIVERSITY
INSTITUTIONAL REVIEW BOARD
Protocol # 13-320
Consent form approved until 6/24/2014
IRB Signature SH/KA

Appendix D

Consent Form – Chinese Version

Morningside Case #209746

哥伦比亚大学教育学院
525 West 120th Street
New York NY 10027
212 678 3000
www.tc.edu

知情同意书

研究描述：谨此邀请您参加一项协作研究，就一些对您重要的问题分享您的经验、知识和专业技能。通过此次协作研究，我们可以促进对服务用户很重要的交谈，帮助增强服务用户之间的连络和关系，了解用于执行研究的工具，并针对与您和其他服务用户相关的问题采取相应措施。您可能因参与此次协作研究而成为一名合作研究者，并以此身份完成您的学业论文。此次协作研究将与哲学博士在麦迪臣社区中心执行。

风险和好处：此次协作研究的相关风险为：因小组讨论而造成的疲劳、厌倦或不适。在该等情况下，您有权暂时或永久退出研究小组，且/或在小组之内或之外解决相关问题。此次协作研究的潜在好处是，可借此机会结识对您重要的问题的其他合作研究者。在探讨和分享与社区宣传相关的知识的同时，让您体验到合作研究者的权利及他们之间的关联性。同样，该研究也存在学生们在平常的课堂或社区外展活动中所遇到的风险。

费用：免费参与。

数据存储时的隐私保护：将对所有参与者的信息进行保密，在所有报告中均以假名提供和使用该等信息。如果您想要成为研究小组的公开身份成员（比如，在知识传播阶段），我们将组织一场交谈，在此期间您可确定哪些人是重要成员（即，您的导师、辅导员以及 PROSpect Place 的总监等），与您讨论您的选择及其后果。所有报告均将锁在研究员办公室的抽屉中。数据文件将保存在研究员的电脑上，设有密码保护。只有研究员和研究小组才能查看报告及衍生的项目数据文件。

研究时间：研究时间大约为每周一个半小时。此次协作研究的持续时间取决于您是否决定加入小组，加入小组完全是自愿的。

将如何使用研究结果：此次协作研究的结果将可能用于辅导员的博士论文。可在会议报告、专题报告会议、期刊出版物或教育场合传播此次协作研究的结果。

TEACHERS COLLEGE, COLUMBIA UNIVERSITY
INSTITUTIONAL REVIEW BOARD
Protocol # 13-320
Consent form approved until 6/24/2014
IRB Signature SH

Appendix E

Participants' Rights – Chinese Version

Morningside Case #209746

哥伦比亚大学教育学院
525 West 120th Street
New York NY 10027
212 678 3000
www.tc.edu

参与者的权利

主要研究员：Joyce Wa Yung，文学硕士，社会科学硕士
研究课题：移民、贫穷和心理健康方面的PAR协作

- 本人已阅读并与研究人员讨论了研究描述。本人已获取机会就此次研究的目的和程序而提出问题。
- 本人完全出于自愿参与此次研究。本人可拒绝参与或随时退出，而不会影响本人将来的医疗护理、就业、学生身份或其他权利。
- 研究人员可凭其专业判断取消我参与研究的资格。
- 如果在研究期间所开发的、与我自愿继续参与研究相关的重要新信息可供使用，则主要研究员将向我提供该信息。
- 如果此研究项目所衍生的任何信息可能暴露了本人的身份，则未经本人的另行同意，不得擅自发布或披露该等信息，除非法律另有明确要求。
- 如果在任何时间本人对此次研究或本人的参与存有任何疑问，本人可联系主要研究员，其将会回答我的问题。主要研究员的电话号码为(646)-884-0626。
- 如果本人在任何时间对此研究的执行有意见或疑虑，或针对本人作为研究课题所享有的权利有疑问，本人应联系哥伦比亚大学教育学院的机构审查委员会/IRB。 IRB 的电话号码为 (212) 678-4105。本人也可写信至 IRB 的以下地址：哥伦比亚大学教育学院，525 W. 120th Street, New York, NY, 10027, Box 151。
- 本人应收到一份研究描述及本参与者权利文档。
- 如果此次研究需要录音和/或录像，则本人（ ）同意接受录音或录像。本人（ ）不同意接受录音/录像。书面、录像和/或录音材料只能供主要研究员及研究小组成员查看。
- 书面、录像和/或录音材料可在此次研究之外的教育场合中查看，（ ）不能在此次研究之外的教育场合中查看。
- 本人的签名即表明本人同意参与此次研究。

TEACHERS COLLEGE, COLUMBIA UNIVERSITY
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Protocol # 13-320
Consent form approved until 6/24/2014
IRB Signature SH

Appendix F

Investigator's Verification of Explanation – Chinese Version

Morningside Case #209746

参与者的签名：_____ 日期：____/____/____

姓名：_____

主要研究员的解释验证

本人兹证明，本人已用适合年龄段的语言向 _____ （参与者的姓名）解释了此次研究的目的和性质。其已获取机会与本人详细讨论此次研究。本人已回答其所有问题，且其已提供肯定性协定（即，同意）参与此次研究。

主要研究员的签名：_____

日期：_____

TEACHERS COLLEGE, COLUMBIA UNIVERSITY
INSTITUTIONAL REVIEW BOARD
Protocol # 13-320
Consent form approved until 01/24/2014
IRB Signature SH

Appendix G

Renewed Informed Consent

Teachers College, Columbia University
525 West 120th Street
New York NY 10027
212 678 3000
www.tc.edu

INFORMED CONSENT

DESCRIPTION OF THE RESEARCH: As a current member of the Hamilton-Madison House (HMH) PAR team, you are invited to participate in the next stage of the project: a study that focuses on the intersectionality of the multiple identities that HMH community members hold and their relationship to mental illness treatment, recovery, and service offerings. Participation in the study will include conversations and research on areas that are important to HMH service users, and will eventually allow us to talk about and plan new services and action initiatives. Along the way, you will be asked to take part in constructing a narrative of our process via discussions and note-taking. This study is part of Joyce Yung's dissertation as a PhD. Candidate in Counseling Psychology, and will take place at Hamilton-Madison House.

RISKS AND BENEFITS: There are no direct benefits to participation in the study, and there will be no reimbursement. However, there may be some potential indirect benefits in that you will receive training in social science research methods and will have the opportunity to generate knowledge that could lead to practical solutions to concerns raised by the team. Risks associated with this collaboration are potentially fatigue, boredom, or discomfort from the group discussions. In such an instance, you have the option to leave the team temporarily or permanently and/ or to work through the issue inside or outside the group setting. As such, the research has the same amount of risk students will encounter during a usual classroom or community outreach activity.

DATA STORAGE TO PROTECT CONFIDENTIALITY: As a co-researcher, you will be fully involved in the data collection process. Outside the project setting itself, your privacy as a participant-researcher will be strictly maintained. All participant information will be held confidential and pseudonyms will be given and used in all reports. In the event that you would like to be an identifiable member of the research team (such as in the knowledge dissemination stage), a conversation will take place during which you can decide who are the important members (i.e. your counselor, the co-facilitator(s), the Director of PROSpect Place, etc.) to help you discuss your choices and its implications. All information will be kept in a locked file cabinet and will be accessible to only study researchers. Data files will be kept on the investigator's computer and will be password protected. Only the investigator and the research team will have access to reports and data files generated from the project.

TIME INVOLVEMENT: Your participation will take approximately 1.5 hours a week. The overall duration of your participation in the study will be up to you and is completely voluntary.

HOW WILL RESULTS BE USED: The results of the study will be used in scholarly publications and/ or presentations. You may wish to co-author or co-present at these times; otherwise, no information identifying other participants will be included.

Thank you very much for considering this invitation. Please feel free to contact me with any questions or comments that you might have.

Joyce Yung, M.A., M.Soc.Sc., Principal Invetsigator
Doctoral Candidate
Department of Counseling and Clinical Psychology
1-646-884-0626

Appendix H

Renewed Participants' Rights

Teachers College, Columbia University
525 West 120th Street
New York NY 10027
212 678 3000
www.tc.edu

PARTICIPANT'S RIGHTS

Principal Investigator: Joyce Wa Yung, M.A., M.Soc.Sc.

Research Title: Participatory Action Research with Chinese Co-Researchers Who Have Serious Mental Health Diagnoses

- I have read and discussed the Research Description with the researcher. I have had the opportunity to ask questions about the purposes and procedures regarding this study.
- My participation in research is voluntary. I may refuse to participate or withdraw from participation at any time without jeopardy to future medical care, employment, student status or other entitlements.
- The researcher may withdraw me from the research at his/her professional discretion.
- If, during the course of the study, significant new information that has been developed becomes available which may relate to my willingness to continue to participate, the investigator will provide this information to me.
- Any information derived from the research project that personally identifies me will not be voluntarily released or disclosed without my separate consent, except as specifically required by law.
- If at any time I have any questions regarding the research or my participation, I can contact the investigator, who will answer my questions. The investigator's phone number is 646-884-0626.
- If at any time I have comments, or concerns regarding the conduct of the research or questions about my rights as a research subject, I should contact the Teachers College, Columbia University Institutional Review Board /IRB. The phone number for the IRB is (212) 678-4105. Or, I can write to the IRB at Teachers College, Columbia University, 525 W. 120th Street, New York, NY, 10027, Box 151.
- I should receive a copy of the Research Description and this Participant's Rights document.
- If video and/or audio taping is part of this research, I ( ) consent to be audio/video taped. I ( ) do NOT consent to being video/audio taped. The written, video and/or audio taped materials will be viewed only by the principal investigator and members of the research team.
- Written, video and/or audio taped materials may be viewed in an educational setting outside the research

  ( ) may NOT be viewed in an educational setting outside the research.

- My signature means that I agree to participate in this study.

Participant's signature: _____ Date:____/____/____

Name: _____

TEACHERS COLLEGE, COLUMBIA UNIVERSITY
INSTITUTIONAL REVIEW BOARD
Protocol # 13-320CR
Consent form approved until 6/23/2015
IRB Signature SH-KC

Appendix I

Renewed Investigator's Verification of Explanation

Investigator's Verification of Explanation

I certify that I have carefully explained the purpose and nature of this research to _____ (participant's name) in age-appropriate language. He/She has had the opportunity to discuss it with me in detail. I have answered all his/her questions and he/she provided the affirmative agreement (i.e. assent) to participate in this research.

Investigator's Signature: _____

Date: _____

TEACHERS COLLEGE, COLUMBIA UNIVERSITY
INSTITUTIONAL REVIEW BOARD
Protocol # 13-320K
Consent form approved until 6/23/2015
IRB Signature SH-KC

Appendix J

Renewed Consent Form – Chinese Version

哥伦比亚大学教育学院
525 West 120th Street
New York NY 10027
212 678 3000
www.tc.edu

知情同意书

研究描述：谨此邀请您参加一项协作研究，就一些对您重要的问题分享您的经验、知识和专业技能。通过此次协作研究，我们可以促进对服务用户很重要的交谈，帮助增强服务用户之间的连络和关系，了解用于执行研究的工具，并针对与您和其他服务用户相关的问题采取相应措施。您可能因参与此次协作研究而成为一名合作研究者，并以此身份完成您的学业论文。此次协作研究将与哲学博士在麦迪臣社区中心执行。

风险和好处：此次协作研究的相关风险为：因小组讨论而造成的疲劳、厌倦或不适。在该等情况下，您有权暂时或永久退出研究小组，且/或在小组之内或之外解决相关问题。此次协作研究的潜在好处是，可借此机会结识对您重要的问题的其他合作研究者。在探讨和分享与社区宣传相关的知识的同时，让您体验到合作研究者的权利及他们之间的关联性。同样，该研究也存在学生们在平常的课堂或社区外展活动中所遇到的风险。

费用：免费参与。

数据存储时的隐私保护：将对所有参与者的信息进行保密，在所有报告中均以假名提供和使用该等信息。如果您想要成为研究小组的公开身份成员（比如，在知识传播阶段），我们将组织一场交谈，在此期间您可确定哪些人是重要成员（即，您的导师、辅导员以及 PROSpect Place 的总监等），与您讨论您的选择及其后果。所有报告均将锁在研究员办公室的抽屉中。数据文件将保存在研究员的电脑上，设有密码保护。只有研究员和研究小组才能查看报告及衍生的项目数据文件。

研究时间：研究时间大约为每周一个半小时。此次协作研究的持续时间取决于您是否决定加入小组，加入小组完全是自愿的。

将如何使用研究结果：此次协作研究的结果将可能用于辅导员的博士论文。可在会议报告、专题报告会议、期刊出版物或教育场合传播此次协作研究的结果。

Appendix K

Renewed Participants' Rights – Chinese Version

Morningside Case #209746

哥伦比亚大学教育学院
525 West 120th Street
New York NY 10027
212 678 3000
www.tc.edu

参与者的权利

主要研究员：Joyce Wa Yung，文学硕士，社会科学硕士
研究课题：移民、贫穷和心理健康方面的PAR协作

- 本人已阅读并与研究人员讨论了研究描述。本人已获取机会就此次研究的目的和程序而提出问题。
- 本人完全出于自愿参与此次研究。本人可拒绝参与或随时退出，而不会影响本人将来的医疗护理、就业、学生身份或其他权利。
- 研究人员可凭其专业判断取消我参与研究的资格。
- 如果在研究期间所开发的、与我自愿继续参与研究相关的重要新信息可供使用，则主要研究员将向我提供该信息。
- 如果此研究项目所衍生的任何信息可能暴露了本人的身份，则未经本人的另行同意，不得擅自发布或披露该等信息，除非法律另有明确要求。
- 如果在任何时间本人对此次研究或本人的参与存有任何疑问，本人可联系主要研究员，其将会回答我的问题。主要研究员的电话号码为(646)-884-0626。
- 如果本人在任何时间对此研究的执行有意见或疑虑，或针对本人作为研究课题所享有的权利有疑问，本人应联系哥伦比亚大学教育学院的机构审查委员会/IRB。 IRB 的电话号码为 (212) 678-4105。本人也可写信至 IRB 的以下地址：哥伦比亚大学教育学院，525 W. 120th Street, New York, NY, 10027, Box 151。
- 本人应收到一份研究描述及本参与者权利文档。
- 如果此次研究需要录音和/或录像，则本人（　　）同意接受录音或录像。本人（　　）不同意接受录音/录像。书面、录像和/或录音材料只能供主要研究员及研究小组成员查看。
- 书面、录像和/或录音材料可在此次研究之外的教育场合中查看，（　　）不能在此次研究之外的教育场合中查看。
- 本人的签名即表明本人同意参与此次研究。

TEACHERS COLLEGE, COLUMBIA UNIVERSITY
INSTITUTIONAL REVIEW BOARD
Protocol # 13-320CR
Consent form approved until 6/23/2015
IRB Signature SH-EC

Appendix L

Renewed Investigator's Verification of Explanation – Chinese Version

Morningside Case #209746

参与者的签名：_____ 日期：____/____/____

姓名：_____

主要研究员的解释验证

本人兹证明，本人已用适合年龄段的语言向 _____（参与者的姓名）解释了此次研究的目的和性质。其已获取机会与本人详细讨论此次研究。本人已回答其所有问题，且其已提供肯定性协定（即，同意）参与此次研究。

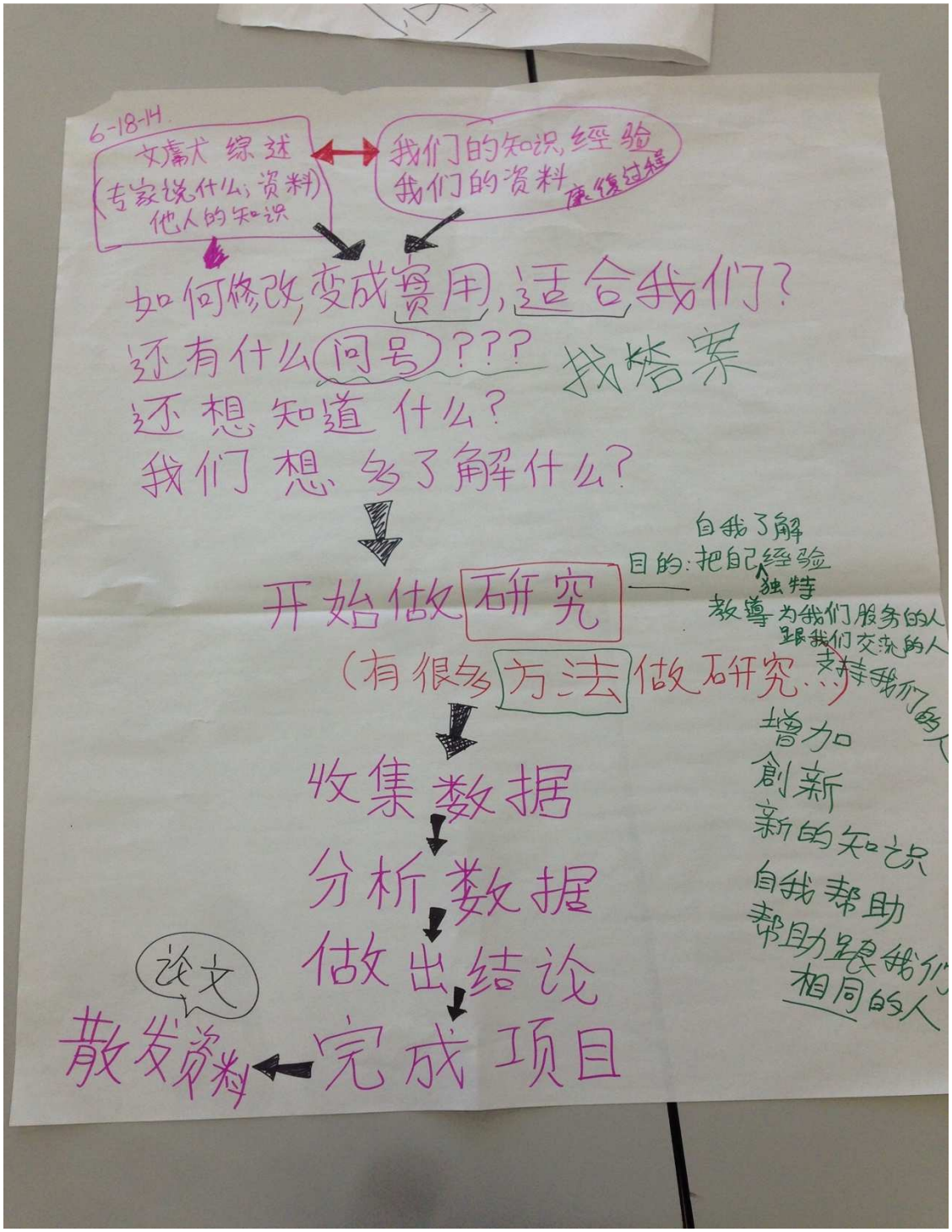
主要研究员的签名：_____

日期：_____

TEACHERS COLLEGE, COLUMBIA UNIVERSITY
INSTITUTIONAL REVIEW BOARD
Protocol # 13-320KK
Consent form approved until 6/23/2015
IRB Signature SH-KC

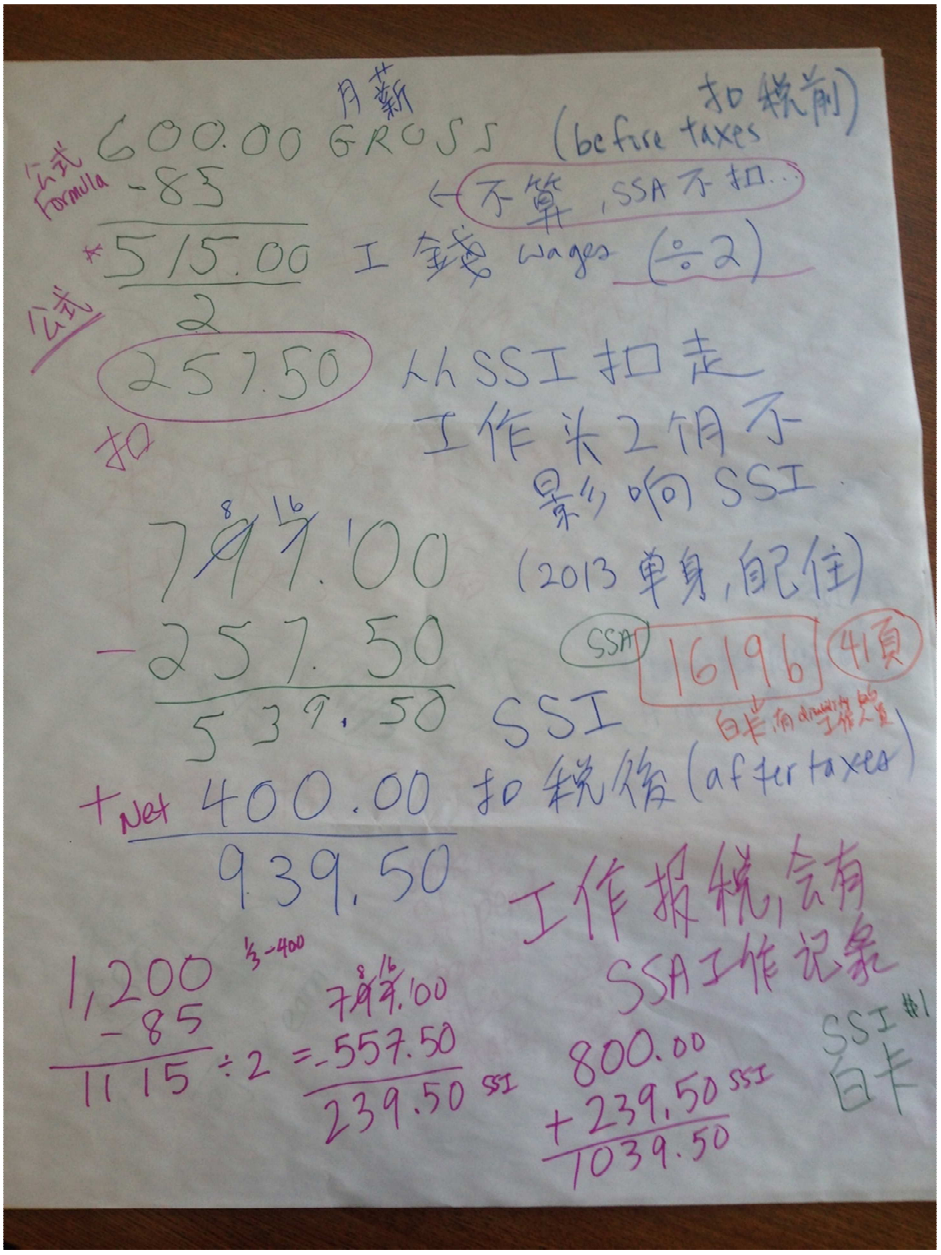
Appendix M

A Snapshot of Notes on the PAR Process Gathered During a Team Meeting



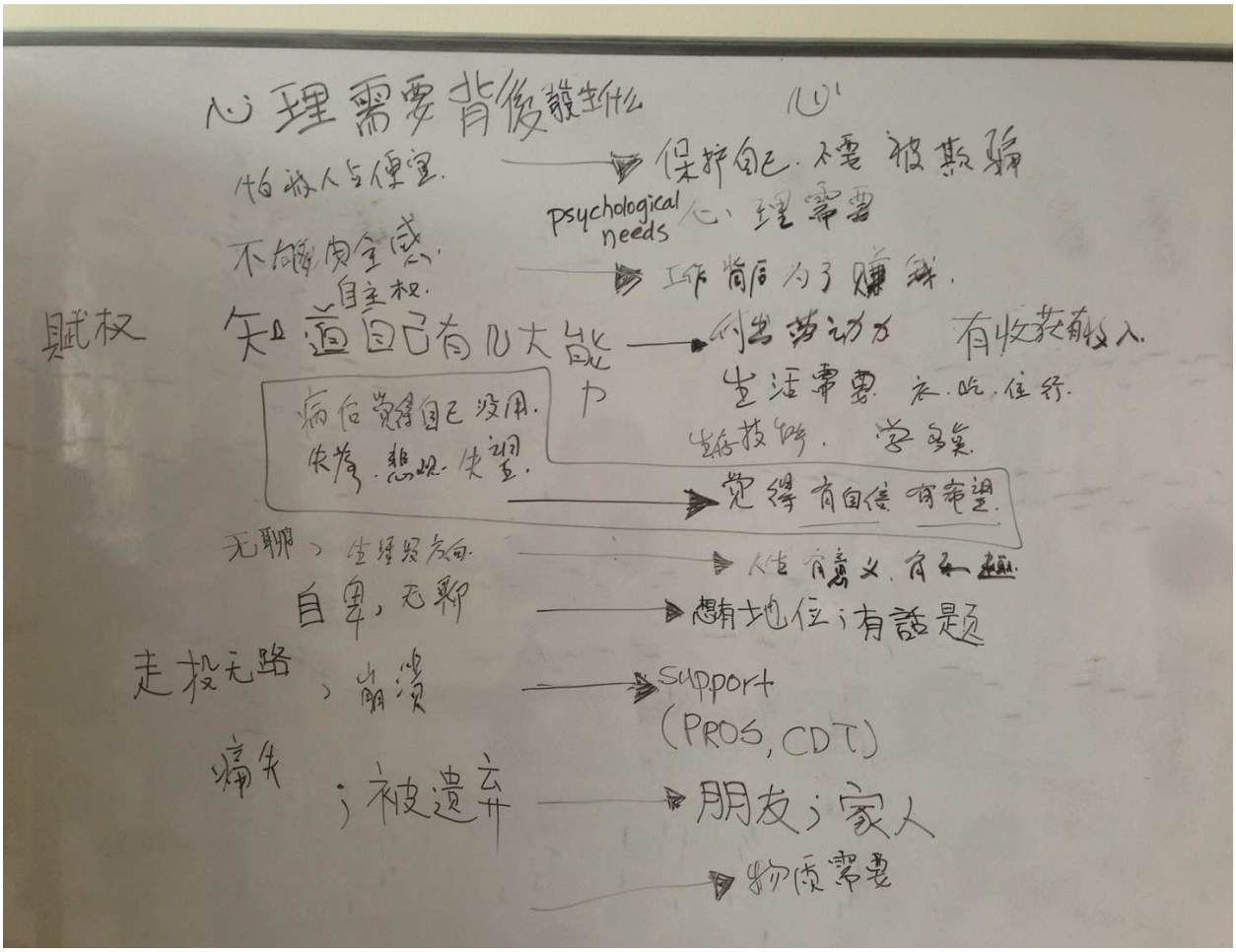
Appendix N

A Snapshot of Notes Gathered on SSI and SSD During a Guest Speaker's Visit



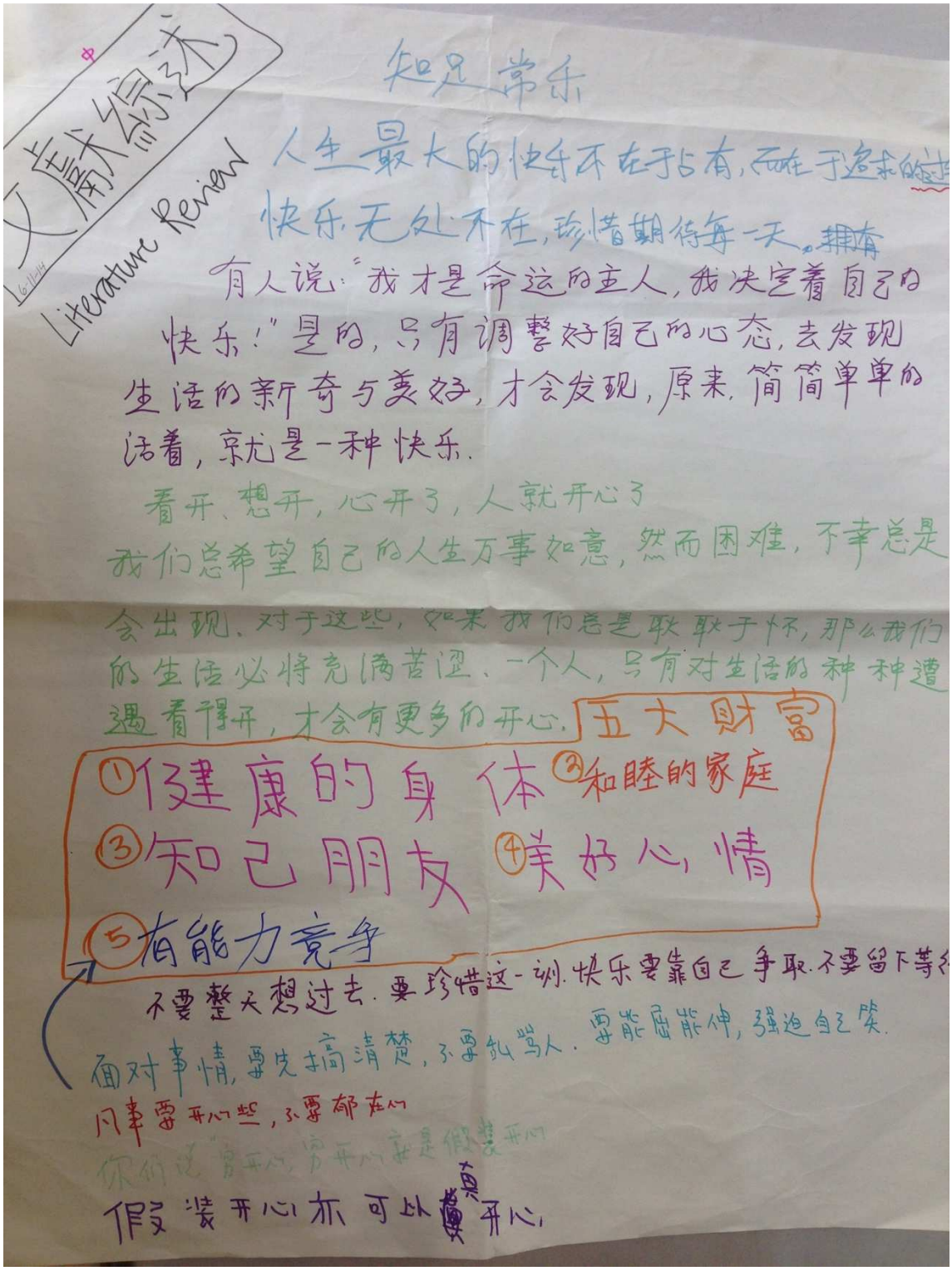
Appendix O

A Snapshot of Concerns Regarding Recovery for PAR Co-Researchers



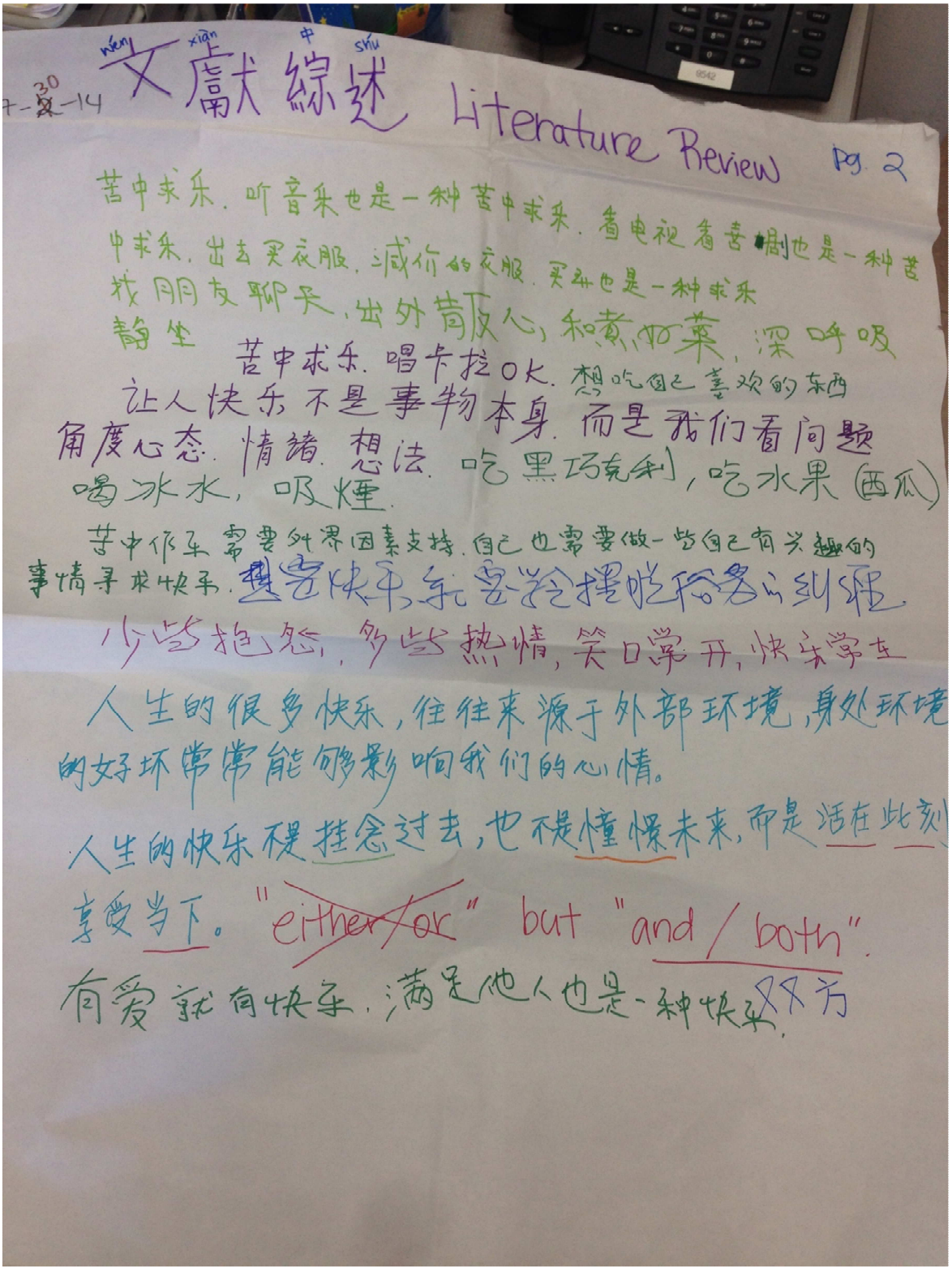
Appendix P

A Snapshot of Notes Gathered During a Literature Review Session



Appendix Q

A Snapshot of Notes Gathered During a Literature Review Session

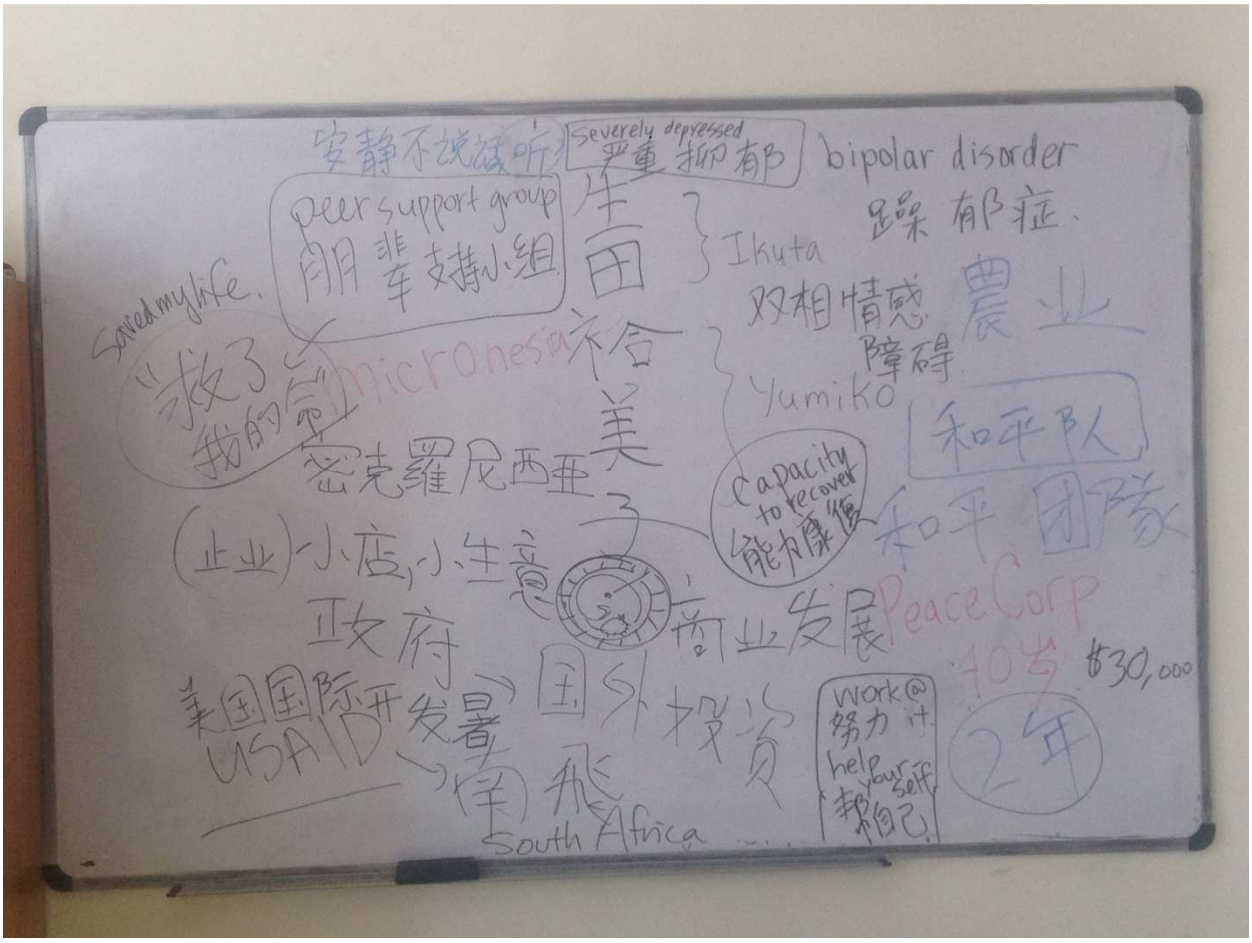


Appendix R

A Snapshot Taken of the Survey Development

Appendix S

Snapshot of Notes Gathered During a Guest Speaker's Visit



Appendix T

The Survey Developed by PAR Co-Researchers on the Subject of Occupational Needs for People in Recovery

康复者对就业的愿望 (问卷)

1) 如果要做工，多少时间适合你？

☐ 星期一到星期五 上午9点到下午5点（1.5小时午餐）（一周大概28到32.5小时）

☐ 一周4天：一天6小时（一周24到28小时）

☐ 一周20到24小时

☐ 一周四天：一天四小时（一周16到20小时）

☐ 周末：一个星期两天：一□天6到8小时（一周12到16小时）

☐ 一周5天：一天三个小时（仅限上午）（一周15小时）

2) 非工作的时候，我需要时间做以下的任务，责任和活动:

（请看清楚有关的活动把它勾起来）

☐吃药休息时间充足

☐管理药物副作用和压力

☐打针

☐社交（探亲友，交朋友，与朋友一起吃饭，逛街，通电话）

☐理财，预算，续期福利

☐看医生，去诊所抽血

☐学习（上课，学语言，进修）

☐休闲（例如：看电视，看报，运动，听歌，购物，用电脑）

☐宗教活动

☐娱乐（例如：散步，打乒乓球，打麻将，打篮球，吃自助餐，看电影，打电动）

☐保持家庭（例如：家务，打扫，买菜，照顾小孩/家长）

☐参加治疗中心

3）你面对什么跟工作有关的困难或障碍想得到解决办法？ (多项选择，请注明所有适用内容)

☐交通（有困难去陌生地方；语言不通；地铁改道；有时候没有车，就不懂怎么走；乘错车，不懂路）

☐情绪症状，波动，害怕，紧张，自卑，忧郁，容易发怒，多年与社会孤立。

☐思想症状，头脑乱，胡思乱想，躁狂症，头脑自大幻想，幻觉，疑心重。

☐行为症状，发脾气，失眠。

☐如果生活，工作太紧张，我们的病容易复发。

☐没有双语的英文课，学习。

☐记忆力有障碍。

☐药物副作用，容易累，很疲倦，有可能会失眠。

☐在陌生环境害怕，紧张。

☐有时候感觉是冤枉，幻听，幻觉， 所以压力大

4）什么人际关系对你康复有帮助? (多项选择，请注明所有适用内容)

☐亲情

☐友情（包括工作关系，朋友之间的友谊）

☐爱情

☐人情

5) 从以上4个主题，你最有兴趣深入了解哪一方面？请提供你的意见给我们PAR研究小组，为了协助我们对未来的调查项目有所帮助。

☐工作时间适合你

☐非工作的重要任务，责任，和活动

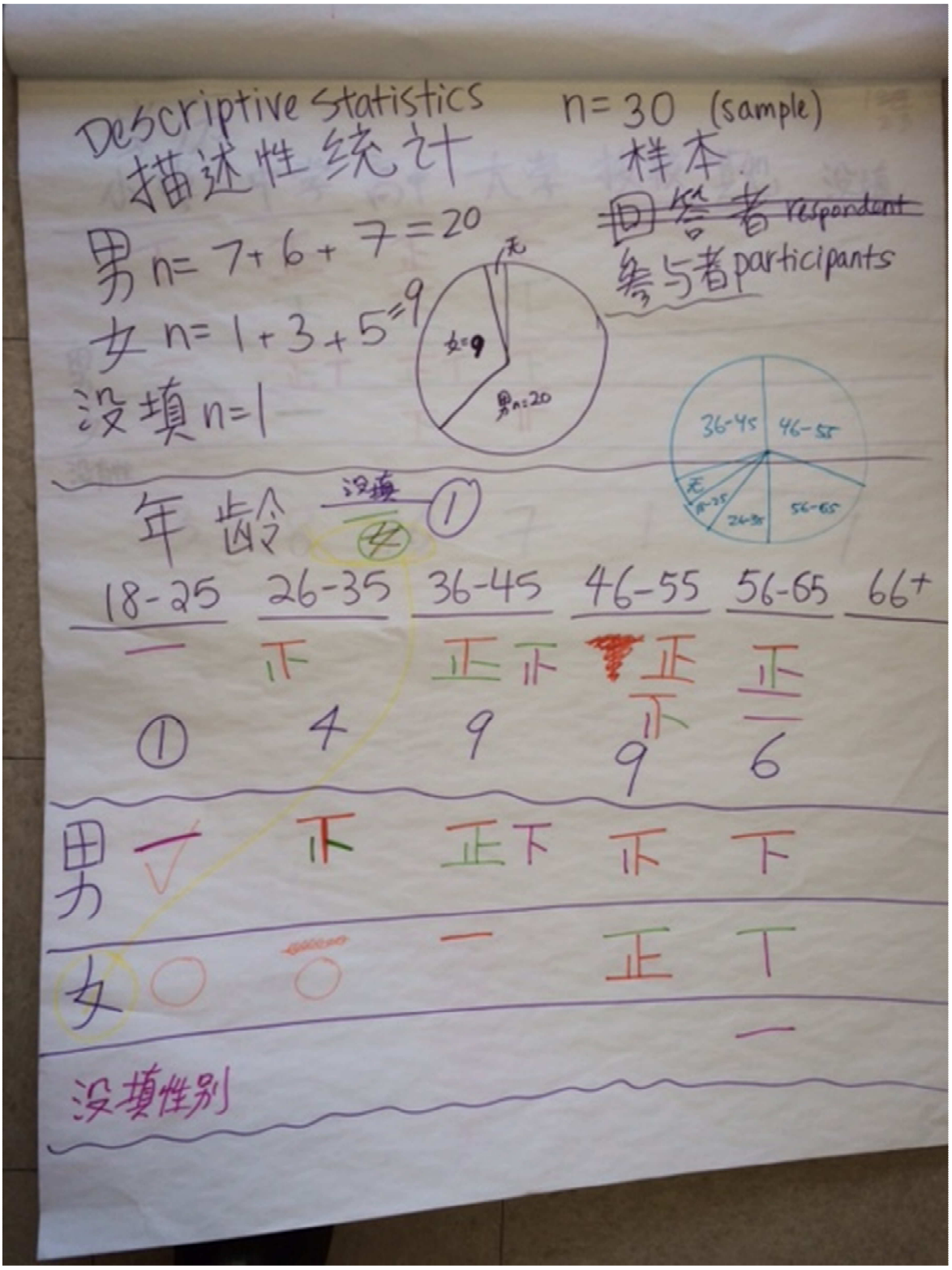
☐面对与工作有关的困难和障碍

☐对康复有帮助的人际关系

☐其他重要主题:_____

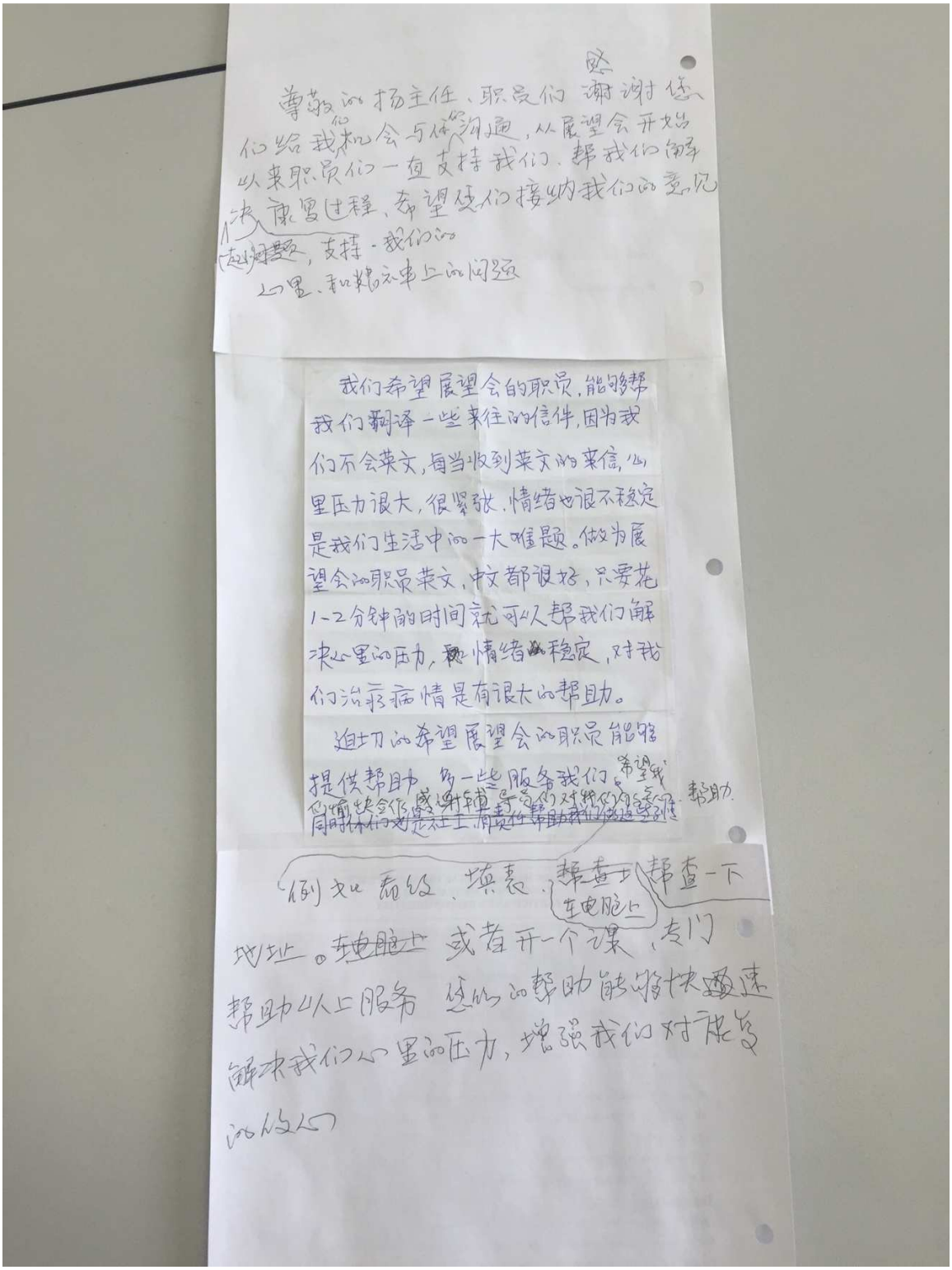
Appendix U

A Snapshot Taken of the Data Calculation



Appendix V

A Snapshot of the Draft Letter Composed to CMHC PROS Management



我们希望展望会的职员，能够帮我们翻译一些来往的信件，因为我们不会英文，每当收到英文的来信，心里压力很大，很紧张，情绪也很不稳定是我们生活中的一大难题。做为展望会的职员英文，中文都很好，只要花1-2分钟的时间就可以帮我们解决心里的压力，和情绪的稳定，对我们治疗病情是有很大的帮助。

迫切的希望展望会的职员能够提供帮助，多一些服务我们。希望我

例如 面谈、填表、帮查卡 帮查一下 主电脑上

地址。主电脑上 或者开一个课，专门帮助以上服务 这样的帮助能够快速解决我们心里的压力，增强我们对病的

Appendix W

A Snapshot of the Final Letter to the CMHC PROS Management